

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

## CERTIFICATE OF DEATH

03458

Reg. Dist. No. 38

1. PLACE OF DEATH: **Baltimore**  
County.....  
City or town.....**Catonsville**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....**25 yrs.**  
Hospital, institution, or street address where death occurred:  
**638 Ingleside Ave.**  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State.....**MD.** County.....**Baltimore**  
City or town.....**Catonsville**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....**638 Ingleside Ave.**  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....**World War 1**

3.(a) FULL NAME  
**Henry Lewis Alsobrook**

3.(b) Social Security Number  
**212 03 5031**

4. Sex.....**Male** 5. Color or race.....**White** 6.(a) Single, married, widowed, or divorced.....**Married**  
6.(b) Name of husband or wife.....**Celestine F. Alsobrook**  
6.(c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.).....**Aug. 21, 1898.**  
8. AGE: Years.....**47** Months.....**7** Days.....**11** If less than one day..... hrs. .... min.

9. Birthplace.....**Florida**  
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....**A. T. & T. Co.**

12. Name.....**Thomas Godwin Alsobrook**

13. Birthplace.....**Greenwood, Fla.**

14. Maiden name.....**Anna Hensler**

15. Birthplace.....**Marianna, Fla.**

16. Informant.....**Mrs. Celestine Alsobrook**

Address.....**638 Ingleside Ave.**

17. **Burial** Date thereof.....**April 6/46.**  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....**Baltimore National**

Location.....**Frederick Rd Baltimore, Md.**

18. Funeral director.....**Harry H. Untzke**

Address.....**4101 Edmondson Ave.**

19. **4-5** 19**46** **Harry H. Miller**  
(Date rec'd by registrar) Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....**April 2/46.** 19....., at.....**7:30 P.M.**

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from  
**Several years** 19....., to.....**April 2 - 1946.**  
and that I last saw him alive on.....**April 2 - 1946.**

Immediate cause of death.....**General asthenia & wasting away of body -**  
Due to.....**Raynaud's disease**  
Due to.....**Arterio Sclerosis**  
Other conditions.....**Gangrene of feet & legs**  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....**E. E. Nicholas M.D.**  
M. D. or other

Address.....**Bethesda 8 Md** Date signed.....**4-8-46**

RECEIVED  
APR 8 1946  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH  
of deceased is shown on

2411 N. Charles St., Baltimore (46-2)

FILM No. 101 APR 29 1946

# CERTIFICATE OF DEATH

Reg. Dist. No. 13459 32

## 1. PLACE OF DEATH:

County Baltimore

City or town Pikesville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred: \_\_\_\_\_

How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Pikesville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 10 Old Lamb Road  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Amos Wesley Armacost Sr.

## 3. (b) Social Security Number

218-09-9321

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Ruth Blaine Armacost

7. Birth date of deceased (mo., day, yr.) Oct 2 - 1865 6. (c) If alive, give age 68 years

8. AGE: Years 81 Months 80 Days 6 If less than one day 20 hrs. 20 min.

9. Birthplace Baltimore Co., Md.  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business Balto Transit Co.

12. Name Wm Armacost

13. Birthplace Upperco. Balto. Co. Md

14. Maiden name Rachel Armacost

15. Birthplace Baltimore Co., Md

16. Informant Mrs. Ruth B. Armacost

Address 10 Old Lamb Rd, Pikesville Md

17. Burial Date thereof April 25 - 46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory David Ridge

Location Pikesville, Maryland

18. Funeral director Frank H. Newell

Address Pikesville, Maryland

19. Apr 24 46 E. E. Nichols  
(Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 19 46, at 7:15 P M

21. CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 6 - 19 44, to 10 Apr 22 19 46

and that I last saw him alive on April 21 - 19 46

Immediate cause of death Carcinoma of Larynx DURATION 2 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Senility

(Include pregnancy within 8 months of death)

Major findings of operations no operations

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE E. E. Nichols Md

Address Pikesville 8 Md Date signed Apr 24 - 46

NEW YORK STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

APR 26 1946

BUREAU V H



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 259

## CERTIFICATE OF DEATH

03460

Reg. Dist. No. 30

1. PLACE OF DEATH:  
 County..... Balto.  
 City or town..... Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 Hood Nursing Home - 5501 Edmondson Ave.  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Md. County.....  
 City or town..... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 2401 Garrison Blvd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

FLORA G. BANDEL

## 3. (b) Social Security Number

4. Sex..... Female  
 5. Color or race..... White  
 6.(a) Single, married, widowed, or divorced..... Widow  
 6.(b) Name of husband or wife..... Lyttleton C. Bandel  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... Nov. 27, 1977  
 8. AGE: Years..... 68 Months..... 4 Days..... 20 If less than one day..... hrs. .... min.

9. Birthplace..... Baltimore, Md.  
 (Town, county, and state)  
 10. Usual occupation..... Housewife  
 11. Industry or business.....

FATHER  
 12. Name..... William H. Gahan  
 13. Birthplace..... Ireland  
 MOTHER  
 14. Maiden name..... Powell  
 15. Birthplace..... England

16. Informant..... Mrs. J. M. Behr, daughter  
 Address..... 489 Kenwood Ave., Delmar, N. Y.

17. Burial..... Date thereof..... 4/20/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Druid Ridge Cen.  
 Location..... Pikesville, Md.

18. Funeral director..... WM. J. TICKNER & SONS  
 Address..... Balto., Md.

19. 4-18 46  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 17, 1946, at 7:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 Apr 14 46 to Apr 17 46  
 and that I last saw him alive on Apr 17 46

Immediate cause of death..... Cerebral Hemorrhage  
 DURATION..... 5 days

Due to..... Cerebral Arterio Sclerosis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Manner of Injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Date signed..... 4/18

83400

STATE OF TEXAS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

3461

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Arbutus  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

4210 Leeds Avenue

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Arbutus  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 4210 Leeds Avenue  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## 3. (a) FULL NAME

Alice F. Barbours

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

March 17, 1862

B. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

84110

hrs.

min.

9. Birthplace

Middletown, Frederick County, Md.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Charles B. Barbours, Sr.

13. Birthplace

Maryland

14. Maiden name

Annie E. Riddlemeyer

15. Birthplace

Maryland

18. Informant

Grace Bradley

Address

15-16 E. 16th Street South  
Birmingham, Alabama

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

4-23-46  
(month) (day) (year)

Cemetery or crematory

London Park

Location

Baltimore, Maryland

18. Funeral director

George L. Schwab

Address

2101 Frederick Avenue19. April 23, 46

(Date rec'd by registrar)

Ger. M. Kieffer

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 19 46 at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 1, 45 to April 22, 46  
and that I last saw him alive on March 1 19 46

Immediate cause of death

Apoplexy

DURATION

1 day

Due to

Cerebral vascular disease?

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Ger. M. Kieffer

M. D. or other

Address

2420 North 3rdDate signed April 23, 46

1345

RECEIVED

MAY 2 1946

BUREAU V.E.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03462

Reg. Dist. No. 38

### 1. PLACE OF DEATH:

County Baltimore

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

16 E. Chesapeake Ave.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No. 16 E. Chesapeake Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Roy Francis Barwick

### 3. (b) Social Security Number

220-05-1643

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Pearl Delta Barwick

7. Birth date of deceased (mo., day, yr.) March 3, 1898 6.(c) If alive, give age 51 years

8. AGE: Years 58 Months 1 Days 17 If less than one day hrs. min.

9. Birthplace Hamilton, Ontario, Canada  
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Self

12. Name William Robert Barwick

13. Birthplace England

14. Maiden name Harriett Elizabeth Murray

15. Birthplace Canada

16. Informant Mrs. Pearl D. Barwick

Address 16 E. Ches. Ave., Towson, Md.

17. Burial Date thereof April 22, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Prospect Hill Cemetery

Towson, Md.

18. Funeral director John Burns Sons

Address Towson, Md.

19. April 22 1946

(Date rec'd by registry) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1946 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 3 to April 18

and that I last saw him alive on April 18

Immediate cause of death

Carcinoma - descending colon

### DURATION

2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of bowels

(Examinable) Date of op. Nov 1945

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

22. SIGNATURE John Burns Sons M. D. or other

Address Towson, Md. Date signed 4/22/46

MARGIN RESERVED FOR BINDING

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VS 15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 3 1946

BUREAU OF



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 132

## CERTIFICATE OF DEATH

 03463 ~~38~~  
 Reg. Dist. No.

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Towson 4, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Since Dec 11, 1944  
 Hospital, Institution, or street address where death occurred:  
Eudowood Sanatorium, Towson 4, Md.  
 How long in hospital or institution? Since Dec 11, 1944

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Essey P.O.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Middleborough  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Charles Jacob Baublitz

## 3. (b) Social Security Number

214-16-9986

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Annie Baublitz  
 7. Birth date of deceased (mo., day, yr.) Sept 11, 1874 6. (c) If alive, give age 70 years  
 8. AGE: Years 71 Months 7 Days  If less than one day  hrs.  min.

9. Birthplace Baltimore County, Md.  
 (Town, county, and state)  
 10. Usual occupation Painter  
 11. Industry or business  
 12. Name John Baublitz  
 13. Birthplace Md.  
 14. Maiden name Mary Martin  
 15. Birthplace Md.

## Personal History- Hospital Records

16. Informant Eudowood Sanatorium, Towson 4, Md.  
 Address Burial  
 17. (Burial, cremation, or removal Which?) Date thereof April 20 - 1946  
 (month) (day) (year)  
 Cemetery or crematory Fork M. E. Cem.  
 Location Fork Md.  
 18. Funeral director Clarence E. Arthur  
 Address Fork Md.  
 19. April 19 1946 G. M. Bacon  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1946 at 4:55 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 11, 1944 to Apr 18, 1946  
 and that I last saw him alive on April 18, 1946

Immediate cause of death Pulmonary tuberculosis  
 Due to   
 Due to   
 Other conditions   
 (Include pregnancy within 3 months of death)

Major findings of operations  Date of op.

Autopsy results   
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide  Date of   
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)   
 Means of injury  Injured at work?

23. SIGNATURE W. E. Bridges M. D. or other   
 Address Towson 4, Maryland Date signed 4-18-46

RECEIVED  
APR 24 1946  
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

# Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

03464

FILM No. - I 04 MAY 16 1946

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:  
 County Baltimore  
 City or town Fork  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State md County Baltimore  
 City or town Fork  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME Samuel T. Beares 3. (b) Social Security Number \_\_\_\_\_

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of ~~husband~~ Elizabeth Beares  
 7. Birth date of deceased (mo., day, yr.) Aug 4 - 1878 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 67 Months 68 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace md (Town, county, and state)  
 10. Usual occupation Farmer  
 11. Industry or business \_\_\_\_\_  
 12. Name Geo. T. Beares  
 13. Birthplace md  
 14. Maiden name Elizabeth Blakeley  
 15. Birthplace md

16. Informant Tilton Beares  
 Address Fork md  
 17. Burial Date thereof April 10 - 46  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Fork M.E. Cem.  
 Location Fork md  
 18. Funeral director Clarence E. Anthony  
 Address Fork md  
 19. April 9 19 46 C. E. Anthony  
 (Date rec'd by registrar) Registrar Deputy Ford

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 19 46, at 3 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 19 46 to April 7 19 46 and that I last saw him alive on April 7 19 46  
 Immediate cause of death Coronary Thrombosis DURATION 36 hrs.  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE Clifford F. Hudson, M.D. M. D. or other \_\_\_\_\_  
 Address Fork md Date signed 4/9/46

80000

OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D.C.

STANDARD FORM NO. 64

4

RECEIVED  
APR 15 1946  
BUREAU V.E.

ATTACHED LIST

NO. 1000000

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

03465

Reg. Dist. No. 30

### 1. PLACE OF DEATH:

County Baltimore  
City or town Catonsville, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7 yrs.  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 14 Sanford Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war Spanish American War

### 3. (a) FULL NAME

Walter Shotwell Bellis, Sr.

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower

6.(b) Name of husband or wife Gertrude Estelle Harkins

7. Birth date of deceased (mo., day, yr.) June 16, 1865 6.(c) If alive, give age 76 years

8. AGE: Years 80 Months 10 Days 8 If less than one day hrs. min.

9. Birthplace Hackettstown N.J.  
(Town, county, and state)

10. Usual occupation Pharmacist retired

11. Industry or business

12. Name John R. Bellis

13. Birthplace New Jersey

14. Maiden name Mary Louise Shotwell

15. Birthplace New Jersey

16. Informant Walter S. Bellis, Jr.

Address 23 Bloomsbury Ave. Catonsville

17. Burial Date thereof Apr. 27, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Woodlawn Cemetery

Location Woodlawn, Md.

18. Funeral director Easton Sons

Address 608 Frederick Ave.

19. 4-26-1946 Harold J. Miller  
(Date rec'd by registrar) (Signature) Registrar

### MEDICAL CERTIFICATION

2D. DATE OF DEATH April - 27 - 1946 at 7:2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov - 24 - 1936 to 4-24-1946

and that I last saw him alive on 4-23-1946

Immediate cause of death Myocardial Degeneration

DURATION 10 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Lloyd Johnson M. D. or other

Address Catonsville, Md. Date signed 4-25-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1946

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C.

RECEIVED  
APR 29 1946  
BUREAU V R



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *St. B*

## CERTIFICATE OF DEATH

Reg. Dist. No. *42*

### 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Relay, 27, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 3-23-46  
 Hospital, institution, or street address where death occurred:  
Relay Sanitarium  
 How long in hospital or institution?..... 3-23-46

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County.....  
 City or town..... Baltimore City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1900 Maryland Avenue Baltimore, 18, Md.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

### 3. (a) FULL NAME

Bode, William Conrad, M.D.

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Married

6.(b) Name of husband or wife..... Gulielma H. Bode

7. Birth date of deceased (mo., day, yr.)..... Mar. 26, 1869 6.(c) If alive, give age..... years

8. AGE: Years..... 77 Months..... - Days..... 13 If less than one day..... hrs. .... min.

9. Birthplace..... Germany (Town, county, and state)

10. Usual occupation..... Physician

11. Industry or business.....

FATHER 12. Name..... William, H. Bode

13. Birthplace..... Germany

MOTHER 14. Maiden name..... Dorothy Crendel

15. Birthplace..... Germany

16. Informant..... wife- Mrs. Gulielma H. Bode

Address..... 1900 Maryland avenue, Baltimore, 18, Md.

17. Burial Date thereof..... April 9, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. James Cemetery, Baltimore, Md.

Location..... Lady's Manor, Baltimore, Md.

18. Funeral director..... John C. Mitchell, Sons

Address..... 1900 Centaur Place

19. 4-8 46 Aw Hadrich  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 7 19 46, at 5:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23 19 46, to April 7 19 46

and that I last saw him alive on April 6 19 46

Immediate cause of death.....

Due to..... Congestion heart failure

Due to..... Cerebral of products with

Due to..... extensive metastases

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE..... Eric P. Gumbel, M.D.

Address..... July 20, 1946 Date signed..... 4/7/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

## CERTIFICATE OF DEATH

Reg. Dist. No. 3D

## 1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Grand Convalescent Home

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 814 E North Ave  
(If rural, give LOCATION)2.(a) If veteran, name war. 43 ✓

## 3. (a) FULL NAME

Monde Bolton (Bolton)

## 3. (b) Social Security Number

215-13-1992

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age. March 24, 1880 years

## 7. Birth date of deceased (mo., day, yr.)

## 8. AGE:

Years

Months

Days

If less than one day

6608

hrs.

min.

## 8. Birthplace

Baltimore MD  
(Town, county, and state)

## 10. Usual occupation

Manufacturing Plant

## 11. Industry or business

Edmond Bolton

## 12. Name

Edmond Bolton

## 13. Birthplace

Harriet Bolton

## 14. Maiden name

Baltimore MD

## 15. Birthplace

May L. Thompson

## 16. Informant

544 E 22nd St

## 17. (Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

## Cemetery or crematory

Trinity

## Location

1317 St Paul St

## 18. Funeral director

1317 St Paul St

## 19. (Date rec'd by registrar)

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## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 2 1946 at 11:45 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946 to April 1946 and that I last saw him alive on April 1st 1946

## Immediate cause of death

Cerebral hemorrhage

## DURATION

3 weeksDue to arterio-sclerosisone year

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. W. SCHEYE, M. D.

3921 EDMONDSON AVE.

M. D. or other

Address

BALTIMORE 29, MD

Date signed

4/3/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-00

## CERTIFICATE OF DEATH

C3468

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 58 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, MarylandHow long in hospital or institution? 58 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1444 Morton Street  
(If rural, give LOCATION)2.(a) If veteran, name war WW-I

## 3. (a) FULL NAME

HARRY H. BOND

## 3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>Negro</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	--

6. (b) Name of husband or wife Mamie Bond6. (c) If alive, give age 47 years7. Birth date of deceased (mo., day, yr.) 5-5-94

8. AGE:	Years	Months	Days	If less than one day
	<u>51</u>	<u>11</u>	<u>15</u>	hrs. min.

9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Chauffeur

11. Industry or business

12. Name Charles Bond13. Birthplace Virginia14. Maiden name Katy Stakma15. Birthplace Maryland16. Informant Clinical Records, Vets. Adm. Hosp.  
Address Ft. Howard, Maryland17. Burial Date thereof 4/23/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National Cemetery  
Baltimore, Md.

Location

18. Funeral director Charles R. Law  
Address 802 Madison Ave Balto., Md.19. 4/22/46 A.W. Hedrick  
(registrar) (year) (month) (day) (year) (signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1946, at 5:20 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
February 21, 1946 to April 20, 1946and that I last saw him alive on April 20, 1946Immediate cause of death Disease of the Heart,  
Mitral Stenosis, Mitral Insufficiency, plus)  
enlargement, myocardial insufficiency

DURATION

(2-21-46enlargement, myocardial insufficiencyOther conditions Chronic nephritis and  
Hypertension  
(Include pregnancy within 3 months of death)Major findings of operations \_\_\_\_\_  
Date of op. \_\_\_\_\_Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert M. Cullison  
R.M. CULLISON, M.D. ACT. CLIN. DIR.  
Address Ft. Howard, Md. Date signed 4-20-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03469

Reg. Dist. No. 40

## 1. PLACE OF DEATH:

County BaltimoreCity or town Whitemarsh  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? life

Hospital, institution, or street address where death occurred:

Philadelphia Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Whitemarsh  
(If outside city or town limits, write RURAL and give nearest town)Street No. Philadelphia Road  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

EVELYN J. BOWERS

## 3. (b) Social Security Number

\*\*\*

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

---

7. Birth date of deceased (mo., day, yr.)

December 24th, 1945

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

327

hrs.

min.

9. Birthplace Balto., Md.

(Town, county, and state)

10. Usual occupation

---

11. Industry or business

FATHER

12. Name

J. Louis Bowers

13. Birthplace

Balto. Co., Md.

MOTHER

14. Maiden name

Evelyn M. Greaver

15. Birthplace

Balto., Md.16. Informant Mr. Louis BowersAddress Philadelphia Rd., Whitemarsh, Md.17. burial

(Burial, cremation, or removal. Which?)

Date thereof Apr. 23, 1946  
(month) (day) (year)Cemetery or crematory ParkwoodLocation Balto., Md.

18. Funeral director

Lozano's Funeral Home

Address

7401 Belair Road

19.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 20th 19 46, at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/18 19 46, to 4/20 19 46  
and that I last saw her alive on 4/20 19 46

Immediate cause of death

Cor Pulm. Embolus

Due to

Branches Lungenarterie

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Thos. S. Sudler

M. D. or other

Address 5323 E. Balto. St. Date signed 4/22/46

CERTIFICATE OF DEATH

RECEIVED  
MAY 4 1944  
BUREAU V.E.







0722

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECEIVED  
MAY 3 1946  
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 163-H

## CERTIFICATE OF DEATH

Reg. Dist. No.

63471 38

## 1. PLACE OF DEATH:

County HarfordCity or town Parkville Baltimore 14  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

Home

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BALTACity or town Parkville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 7804 Gilman P Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Thelma Elizabeth Brown

## 3. (b) Social Security Number

-

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Caton Wm Brown6. (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.)

January 1-1914

8. AGE:

Years

Months

Days

If less than one day

32

hrs.

min.

9. Birthplace

Balta Md  
(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

MOTHER FATHER

12. Name

Scully

13. Birthplace

Md

14. Maiden name

Elizabeth E. Sculley

15. Birthplace

Md

16. Informant

Caton Wm Brown

Address

7804 Gilman P Ave

17.

(Burial, cremation, or removal. Which?)

Date thereof

5-4-46  
(month) (day) (year)

Cemetery or crematory

Parkwood

Location

Balta Md

18. Funeral director

Address

5305 Harford Rd

19.

4/30  
(Date rec'd by registrar)

19

46Joe H. H. H.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 29, 1946 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

None 19... to 19...and that I last saw him alive on 4/29/46 19...Immediate cause of death Carbon monoxide poisoning - SuicideDue to MelancholiaDue to 1940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

## CERTIFICATE OF DEATH

★0347232  
Reg. Dist. No.

<b>1. PLACE OF DEATH:</b> County <u>Baltimore</u> City or town <u>Stevenson</u> (If outside city or town limits, write RURAL NEAR and give town) Street address, hospital, or institution: <u>Hillside Road</u> Stay in hospital or inst. (yrs., or mos., or days) _____ Stay in this community (yrs., or mos., or days) _____				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Baltimore</u> City or town <u>Stevenson</u> Ward No. _____ (If outside city or town limits, write RURAL NEAR and give town) Street No. <u>Hillside Road</u> (If rural give LOCATION) _____ 2(a) IF VETERAN, NAME WAR _____			
<b>3. (a) FULL NAME</b> <u>Elmer Fishpough Burnham</u>				<b>3. (b) Social Security Number</b> _____			
<b>4. Sex</b> <u>Male</u>		<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Married</u>		<b>MEDICAL CERTIFICATION</b>	
<b>6 (b) Name of husband or wife</b> <u>Pearl Marcella Burnham</u>				<b>20. DATE OF DEATH</b> <u>4/14/46</u> 19____ at <u>9:30</u> A.M.			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>February 27 1890</u>				<b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from 19____ to <u>4-14-46</u>			
<b>8. AGE:</b> Years <u>56</u> Months <u>1</u> Days <u>15</u> If less than one day _____ hrs. _____ min.				and that I last saw him alive on <u>4-13-46</u> 19____			
<b>9. Birthplace</b> <u>Chestnut Ridge, Balto. Co., Md.</u> (Town, county, and state)				<b>Immediate cause of death</b> <u>Carcinoma of</u> <u>breast</u>			
<b>10. Usual occupation</b> <u>Farmer</u>				<b>DURATION</b> <u>12 yrs</u>			
<b>11. Industry or business</b> <u>Tenant Farmer</u>				<b>Due to</b> _____			
<b>12. Name</b> <u>Elijah Burnham</u>				<b>Due to</b> _____			
<b>13. Birthplace</b> <u>Maryland</u>				<b>Other conditions</b> <u>Cachexia</u>			
<b>14. Maiden name</b> <u>Mary Lee</u>				(Include pregnancy within 3 months of death)			
<b>15. Birthplace</b> <u>Maryland</u>				<b>Major findings:</b> Of operations _____			
<b>16. Informant</b> <u>Mrs. Pearl M. Burnham</u> Address <u>Hillside Road, Stevenson, Md.</u>				<b>Of autopsy</b> _____			
<b>17. Burial</b> (Burial, cremation, or removal. Which?) Date thereof <u>April 16, 1946</u> (month) (day) (year) Cemetery or crematory <u>Carroll's Cemetery</u> Location <u>Chestnut Ridge, Balto. Co., Md.</u>				<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) (County) (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____			
<b>18. Funeral director</b> <u>John Burns' Sons</u> Address <u>Towson, Maryland</u>				<b>3. SIGNATURE</b> <u>James L. Saffell</u> Address <u>Reston, Va.</u> M. D. or other _____ Date signed <u>4/14/46</u>			
<b>19. (Date rec'd by registrar)</b> <u>Apr 17 1946</u> Registrar <u>W. G. Nichols</u>							

STACU

RECEIVED  
APR 18 1946  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: .....

How long in hospital or institution? .....

## 3. (a) FULL NAME

ANNABELL CAIRNCROSS

## 3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife William W. Cairncross6. (c) If alive, give age D. years7. Birth date of deceased (mo., day, yr.) May 23, 18668. AGE: Years 79 Months 10 Days 15 If less than one day  
..... hrs. .... min.9. Birthplace Howard County Maryland  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business At Home

12. Name .....

13. Birthplace Maryland14. Maiden name Annabell Hobbs15. Birthplace Maryland16. Informant Mrs. May MeyerAddress 451 Yale Ave.17. BURIAL Date thereof APRIL 10/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory WOODLAWN CEMETERYLocation WOODLAWN MARYLAND18. Funeral director J. D. Skippert & SonAddress 1300 EUTAW PLACE.....c19. 4-10 46 Cancelled  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County .....City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 451 Yale Ave.  
(If rural, give LOCATION)

2. (a) If veteran, name war .....

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 7th. 46 3: P.M.  
19..... at ..... M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
31 6 1946 to 4 7 1946  
and that I last saw him/her alive on 4 1 1946

Immediate cause of death .....

DURATION

Acute Corbatic Failure 1 dayDue to Generalized ArteriosclerosisDue to Coronary Arterial DiseaseOther conditions Semipalm 5 yr

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury .....

Injured at work? .....

23. SIGNATURE Joseph S. Law (auth. mrd)Address Washington Blvd. M. D. or otherDate signed 4/9/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03474

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Stonleigh  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Urmscott Nursing Home

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Stonleigh  
(If outside city or town limits, write RURAL and give nearest town)Street No. 812 Chester Ave  
(If rural, give LOCATION)2.(a) If veteran, name war W

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 8 19 46 at 89 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 28 19 46 to April 8 19 46  
and that I last saw he alive on April 7 19 46

Immediate cause of death

Cerebral Hemorrhage  
Hypertensive Cardio-  
Vascular Disease

DURATION

12 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address 5103 Bayford Rd. Date signed 4/8/46



MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 3

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

1. PLACE OF DEATH mt. Washington  
 CITY OF BALTIMORE: (No. 1701 SUGRAVE St., ..... Ward)  
 Length of residence in city or town where death occurred 68 yrs. .... mos. .... ds. How long in U. S. If of foreign birth? .... yrs. .... mos. .... ds.  
 2. FULL NAME LAWRENCE SANGSTON CLARKE  
 (a) Residence: No. 1701 SUGRAVE St., ..... Ward. MD.  
 (Usual place of abode) (If non-resident give city or town and State)

03475 Registered No. 38  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
 If U.S. Veteran specify WAR .....

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. Color or Race White 5. Single, Married, Widowed, or Divorced (write the word) Married  
 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of LAURA GRAFFLIN CLARKE  
 6. DATE OF BIRTH (month, day, year) OCT 19, 1877  
 7. AGE Years Months Days If LESS than 1 day, .... hrs. or .... min.  
68 5 20  
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. SALESMAN  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. PAPER Co.  
 10. Date deceased last worked at this occupation (month and year) FEB 1946 11. Total time (years) spent in this occupation 42

12. BIRTHPLACE (city or town) BALTIMORE (State or country) MD.

MOTHER FATHER  
 13. NAME HENRY E. CLARKE  
 14. BIRTHPLACE (city or town) Balt, Md (State or country)  
 15. MAIDEN NAME Mary Sangston  
 16. BIRTHPLACE (city or town) Catonsville Co. Md (State or country)

17. INFORMANT Laura Grafflin Clarke (Address) 1701 Sugraue ave

18. BURIAL, CREMATION, OR REMOVAL David Ridge Cemetery, Balt. Place Date 4/12/1946

19. UNDERTAKER John O. Mitchell & Sons (Address) 1900 Eastern Pl

20. FILED 4/12, 1946 D. W. Hedrick Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) April 11<sup>th</sup>, 1946

22. I HEREBY CERTIFY That I attended deceased from January, 1946 to April 9, 1946

First saw him alive on 4/9/46, 19..... Death is said

to have occurred on the date stated above, at 5:35 P. a.m.

The principal cause of death and related causes of importance were as follows:

Pneumonia Heart Dist (2)  
Mitral Stenosis (2)  
Central Emphysema (2)

Other contributory causes of importance:

Pulmonary edema 4/11/46  
20 3:00 p

Was an operation performed? No Date of .....

For what disease or injury? .....

What test confirmed diagnosis? ..... Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public

place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?

No If so, specify .....

(Signed) Walter E. Kaufman M. D.

(Address) Baltimore, Md.

S.S. No. 213-03-6707

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

03476

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Mannothville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 37 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Baltimore  
 City or town Mannothville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex M. 5. Color or race W 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Louis Claus  
 6. (c) If alive, give age 84 years  
 7. Birth date of deceased (mo., day, yr.) January 22, 1863  
 8. AGE: Years 83 Months 3 Days 6 If less than one day  
 hrs. min.

9. Birthplace Md.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Own Home  
 12. Name Henry Galy  
 13. Birthplace Germany  
 14. Maiden name Anna Grace  
 15. Birthplace Germany

16. Informant Mr. Louis Claus  
 Address Mannothville, Md.  
 17. Burial Date thereof May 1, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Wards Chapel Cem.  
 Location Liberty Road, Holbrook, Md.  
 18. Funeral director C. Harry Zieser  
 Address Lakeside, Md.  
 19. 4/25/46 19 46 Tom E. Martin  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 19 46, at 6 A. M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to April 28, 1946  
 and that I last saw him alive on April 27, 1946  
 Immediate cause of death Cardiovascular Disease  
 DURATION  
 Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Tom E. Martin M. D. or other  
 Address Randallstown Date signed 4/25/46

RECEIVED

MAY 4 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-2

## CERTIFICATE OF DEATH

03477

Reg. Dist. No.

32

## 1. PLACE OF DEATH:

County Balto.City or town Owings Mills  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Owings Mills  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

JAMES L. CONSTANTINE

## 3. (b) Social Security Number

212-26-4920

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	--

6. (b) Name of husband or wife Bertha Constantine7. Birth date of deceased (mo., day, yr.) March 30, 1870  
6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:	Years	Months	Days	If less than one day
<u>76</u>		<u>0</u>	<u>5</u>	_____ hrs. _____ min.

9. Birthplace Reisterstown, Md.  
(Town, county, and state)10. Usual occupation Night Watchman11. Industry or business Park & Tillford12. Name Wm. Constantine13. Birthplace Balto. Co., Md.14. Maiden name Unknown

15. Birthplace

16. Informant Mr. W. Elmer ConstantineAddress 5265 Nelson Ave. 1517. Burial Date thereof 4/8/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Woodlawn Cem.Location Woodlawn, Md.18. Funeral director WM. J. TICKNER & SONSAddress Balto., Md.19. chr 6 - 19 46 E.E. Michaels  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 19 46, at 6:00A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Several weeks 19 46 to April 5 19 46, and that I last saw him alive on April 3 19 46Immediate cause of death Coronary Thrombosis DURATION SuddenDue to Chronic MyocarditisDue to Arterio SclerosisOther conditions Senility

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE E.E. Michaels M. D. or otherAddress Preserve 8, Md Date signed 4-6-46

RECEIVED

APR 9 1946

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03478

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County Balto.  
City or town Landsdown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
2111 Aletta Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3709 Gough St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Crawford)  
Laura A. Crawford (Laura Strome Violette

## 3.(b) Social Security Number

217-16-5791

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

D

6.(b) Name of husband or wife

7. Birth date of  
deceased (mo., day, yr.) Sept. 26, 18938. AGE: Years Months Days If less than one day  
52 6 25 hrs. min.9. Birthplace Pa.  
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name Michael Strome13. Birthplace Pa.14. Maiden name Unk.15. Birthplace Pa.16. Informant Mr. Frank RosenthalAddress 3709 Gough St.17. Burial Date thereof Apr. 24/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oak Lawn Cem.Location Balto. Md.18. Funeral director Philip Hurwitz SonsAddress 2024 Orleans St.19. 4/24/46 A.W. Hedrick  
(Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 21, 1946 19 46 at 8:30 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
4/1/46 19 46 to 4/21 19 46  
and that I last saw her alive on 4/21/46 19 46Immediate cause of death Carcinoma of bladder DURATION 6 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Benjamin Miller M. D. or otherAddress 2030 W. W. Lane Date signed 4/23/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

<b>1. PLACE OF DEATH:</b> County..... <u>Baltimore</u> City or town..... <u>Catonsville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>18 years, 17 days</u> Hospital, institution, or street address where death occurred: <u>Spring Grove State Hospital</u> How long in hospital or institution?..... <u>18 years, 17 days</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... City or town..... <u>Baltimore</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>1112 Guilford Ave.</u> (If rural, give LOCATION) 2.(a) If veteran, name war..... <u>-</u>				
<b>3. (a) FULL NAME</b> <u>Samuel M. Crawford</u>				<b>3. (b) Social Security Number</b>				
<b>4. Sex</b> <u>male</u>		<b>5. Color or race</b> <u>white</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>single</u>		<b>MEDICAL CERTIFICATION</b> <b>20. DATE OF DEATH</b> ..... <u>4/1/46</u> ..... 19... <u>46</u> ..... at... <u>10 A.M.</u> <b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>4/1/46</u> ..... 19... <u>46</u> ..... to... <u>4/1/46</u> ..... 19... <u>46</u> ..... and that I last saw him..... alive on..... <u>no date</u> ..... 19... <b>Immediate cause of death</b> ..... <u>Arteriosclerotic Cardiac</u> <u>Vascular Disease</u> <b>Due to</b> ..... <b>Due to</b> ..... <b>Other conditions</b> ..... <u>None</u> (Include pregnancy within 3 months of death) <b>Major findings of operations</b> ..... <u>None</u> Date of op..... <b>Autopsy results</b> ..... <u>None</u> <b>PHYSICIAN:</b> Please underline the cause to which death should be charged statistically. <b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town)..... (County)..... (State)..... Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....		
<b>6. (b) Name of husband or wife</b> ..... <u>no</u>		<b>6. (c) If alive, give age</b> ..... years						
<b>7. Birth date of deceased (mo., day, yr.)</b> ..... <u>May 31, 1886</u>		<b>8. AGE:</b> Years..... <u>59</u> Months..... <u>10</u> Days..... <u>1</u> If less than one day..... hrs. min.						
<b>9. Birthplace</b> ..... <u>Baltimore, Md.</u> (Town, county, and state)		<b>10. Usual occupation</b> ..... <u>general laborer</u> <b>11. Industry or business</b> ..... <u>laboring</u>						
<b>FATHER</b>	<b>12. Name</b> ..... <u>George C. Crawford</u>		<b>13. Birthplace</b> ..... <u>Baltimore, Md.</u>		<b>14. Maiden name</b> ..... <u>Clara J. Marshall</u>		<b>15. Birthplace</b> ..... <u>Baltimore, Md.</u>	
	<b>16. Informant</b> ..... <u>Hospital Records</u>		<b>Address</b> ..... <u>Catonsville 28, Md.</u>		<b>17. Burial</b> ..... <u>4/5/46</u> (Burial, cremation, or removal. Which?) Date thereof..... (month) (day) (year) Cemetery or crematory..... <u>Green Mount</u> Location..... <u>Balto. Md.</u>		<b>18. Funeral director</b> ..... <u>William Cook Inc.</u> Address..... <u>1217 St. Paul St.</u>	
	<b>19. 4-3</b> ..... 19... <u>46</u> (Date rec'd by registrar)		<b>23. SIGNATURE</b> ..... <u>George E. Bunting</u> DEPUTY MEDICAL EXAMINER OF MARYLAND COUNTY M. D. or other Address..... <u>Elliot City, Md.</u> Date signed..... <u>4/1/46</u>					

Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

## CERTIFICATE OF DEATH

03480

Reg. Dist. No. 38

## 1. PLACE OF DEATH

County Baltimore  
 City or town Lutherville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Ridgely Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Lutherville  
 (If outside city or town limits, write RURAL and give nearest town)Street No. Ridgely Road  
 (If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

John W. Cursey

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife:

Mary L.

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Apr. 14 1946 at 5:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 21 1943, to Apr 14 1946.and that I last saw him alive on Apr 14 1946.

Immediate cause of death

Heart failure

DURATION

4 hrs.

Due to

Pneumonia, toxemia4 hrs.

Due to

Coronary Thrombosis10/21/43Other conditions arterio sclerosisarterio

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Bennett A. Blain  
Lutherville, Md

M. D. or other

Date signed

4/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

*Johnson*  
3432 Frederick Ave

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-6

## CERTIFICATE OF DEATH

03481 30

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County... Baltimore  
City or town... Catonsville Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Williams Henry Deahl

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widowed

6. (b) Name of husband or wife

Frances Deahl

7. Birth date of

deceased (mo., day, yr.)

July 28-1868

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

77 8 23

9. Birthplace

Berryville Va.

(Town, county and state)

10. Usual occupation

Cabinet Maker

11. Industry or business

12. Name

William Deahl

13. Birthplace

Berryville Va.

14. Maiden name

Johnson

15. Birthplace

Milled V. Kruger

16. Informant

Address 1010 Frederick Ave17. Burial

(Burial, cremation, or removal. Which?)

Date thereof April 23-46

(month) (day) (year)

Cemetery or crematory

Mount Carmel

Location

Balto. Md.

18. Funeral director

Address Ellsworth Armacost3911 Liberty Heights Ave.19. 4-2319 46

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County...  
City or town... Catonsville Md  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1010 Frederick Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 19 46 at 11:58 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 20 19 45 to April 20 19 46and that I last saw him alive on April 18 19 46

Immediate cause of death

General CarcinomatosisDue to Carcinoma of Orbit

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Eliot W. Johnson MDAddress 3432 Frederick Ave Date signed

1980

STATE OF TEXAS

Call from Zell

one transcript

one permit

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74a

## CERTIFICATE OF DEATH

03482

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town CatonsvilleHow long in above place of death? 19 years, 11 months, 17 daysHospital, institution, or street address where death occurred:  
Spring Grove State HospitalHow long in hospital or institution? 19 yrs., 11 mo.s., 17 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 302 Vineyard Lane  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Nellie Deane

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Divorced6.(b) Name of husband or wife William Deane6.(c) If alive, give age Unknown years7. Birth date of deceased (mo., day, yr.) 1907?

## 8. AGE:

Years

39?

Months

unk.

Days

unk.

If less than one day

.....hrs. ....min.

9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name Jessie Reeves13. Birthplace South Carolina14. Maiden name Nellie Bowersox15. Birthplace Maryland16. Informant Hospital records, Spring Grove HospitalAddress Catonsville, 28, Md.17. Date of death 4-24-46  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Spring GroveLocation Catonsville, Md.18. Funeral director William L. L. L.Address 1214 St. Paul St.19. 4-22 46 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 21st, 1946 19..... at 4:25 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
May 4, 1926 19..... to April 21 19. 46and that I last saw h.....er alive on April 21st, 1946 19.....Immediate cause of death  
Acute myelogenous leukemiaDURATION  
15 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....Henry C. A. Mead, M.D.Address.....Catonsville, 28 Date signed 4/21/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93A

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

## 1. PLACE OF DEATH:

County..... Balto.  
 City or town..... Randallstown  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Clifmar Rd.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Balto.

City or town..... Randallstown  
 (If outside city or town limits, write RURAL and give nearest town)

Street No..... Clifmar Rd.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

HANNAH EMMA DELAPLANE

## 3. (b) Social Security Number

220-07-9073

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Single

6.(b) Name of husband or wife..... -

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... July 25, 1860

8. AGE: Years..... 85 Months..... 8 Days..... 9 If less than one day..... hrs. .... min.

8. Birthplace..... Baltimore, Md.  
 (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

12. Name..... Joseph Edmund Delaplane13. Birthplace..... Md.14. Maiden name..... Catherine Hiteshow15. Birthplace..... Carroll Co., Md.16. Informant..... Mrs. C. Elinor DulinAddress..... Randallstown, Md.

17. Burial..... 4/6/46  
 (Burial, cremation, or removal, Which?)..... (month) (day) (year)

Cemetery or crematory..... Loudon Park Cem.Location..... Balto., Md.18. Funeral director..... WM. J. TICKNER & SONSAddress..... Balto., Md.

19. 4/4/46 1946 Wm. E. Martin  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Apr. 4, 1946, at 2:15A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1941 to Apr. 4, 1946, and that I last saw him alive on April 3, 1946.

Immediate cause of death..... Arteriosclerosis Cerebral

DURATION

Due to..... Cardiovascular Dis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE..... Wm. E. Martin

M. D. or other

Address..... Randallstown Date signed 4/4/46



RECEIVED

APR 9 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-1)

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 yrs., 1 month, 8 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 3 yrs., 1 month, 8 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 300 Carey Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

William Dell

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed  
 6.(b) Name of husband or wife Mary Pierce  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) November 23, 1874  
 8. AGE: Years 71 Months 5 Days 3 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore County, Maryland  
 (Town, county, and state)  
 10. Usual occupation Weaver  
 11. Industry or business Weaving  
 12. Name Nelson Dell  
 13. Birthplace Baltimore County, Maryland  
 14. Maiden name Mary Davis  
 15. Birthplace Baltimore County, Maryland  
 16. Informant Hospital records  
 Address Catonsville-28, Maryland  
 17. Burial Date thereof May 3, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Spring Grove State Hospital  
 Location Catonsville 28, Maryland  
 18. Funeral director Spring Grove State Hospital  
 Address Catonsville 28, Maryland  
 19. 5-4- 19 46 Harry S. Miller Registrar  
 (If daily registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 19 46 at 10:25 a.m.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18 19 43 to April 26 19 46  
 and that I last saw him alive on April 26 19 46

Immediate cause of death Carcinoma of right maxilla DURATION Indef.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results as above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other \_\_\_\_\_  
 Address Catonsville-28, Md. Date signed 5-2-46

RECEIVED  
MAY 5 1946  
BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-6)

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Mount Wilson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 yrs., 11 mos., 30 days  
 Hospital, institution, or street address where death occurred Mt. Wilson Branch, Md. Tuberculosis Sanatorium  
 How long in hospital or institution? 4 yrs., 11 mos., 30 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Geo. Co.  
 City or town Anacostia, Oxen Hill  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. R.# 2.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Frances M. Delozier

## 3. (b) Social Security Number

None

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-------------------------	----------------------------------	--

6. (b) Name of husband or wife John Delozier  
 6. (c) If alive, give age 45 years  
 7. Birth date of deceased (mo., day, yr.) July 9, 1908  
 8. AGE: Years 37 Months 9 Days 15 If less than one day  
 .....hrs. ....min.

9. Birthplace Nottingham, Maryland  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business  
 FATHER  
 12. Name Thomas Layman  
 13. Birthplace Maryland  
 MOTHER  
 14. Maiden name Mary E. Rawlings  
 15. Birthplace Maryland

16. Informant Mrs. Frances M. Delozier  
 Address R.#2, Anacostia, Oxen Hill, Md.  
 17. Burial Date thereof April 27, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Church of Assumption Cem.  
 Location Upper Marlboro, Maryland  
Ullrich Funeral Home  
 18. Funeral director  
 Address 2004 Orleans St., Balto., Md.  
 19. April 24, 1946  
 (Date rec'd by registrar) Earl T. Webster  
 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 24, 19 46, at 8:15 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
April 25, 19 41, to April 24, 19 46  
 and that I last saw her alive on April 24, 19 46  
 Immediate cause of death  
Pulmonary Tuberculosis DURATION 6 Yrs.  
 Due to Tubercle Bacilli  
 Due to  
 Other conditions Amyloidosis  
 (Include pregnancy within 8 months of death)  
 Major findings of operations No operation  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE Stewart A. Shaffer M.D. M. D. or other  
 Address Mount Wilson, Md. Date signed 4/24/46

Rec'd 4-27-46

RECEIVED

APR 29 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

## CERTIFICATE OF DEATH

C3486

Reg. Dist. No. 31

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Wilbur Ave. Randallstown  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Rural  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Wilbur Ave. Randallstown  
 (If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Ruth H. Disharoon

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Prettyman Disharoon

7. Birth date of deceased (mo., day, yr.)

July 15, 1910

6. (c) If alive, give age

26 years

8. AGE: Years Months Days If less than one day

35 2 20 hrs. min.

9. Birthplace

Baltimore, Md.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Charley A. Smith

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Ruth H. Disharoon

Address

Wilbur Ave. Randallstown

17. Burial (Burial, cremation, or removal. Which?) Date thereof

Burial 4-9-46  
(month) (day) (year)

Cemetery or crematory

St. Olive Roman

Location

Randallstown

18. Funeral director

Wm. Cook Inc.

Address

1217 St. Paul St.19. 4/7/46 1946 Wm. E. Martin  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1946 at 1946 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1945 to Apr. 7, 1946and that I last saw her alive on April 16, 1946

Immediate cause of death

Carcinomatosis

Due to

Carcinoma of Breast

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Wm. E. MartinAddress RandallstownDate signed 4/7/46



RECEIVED

APR 9 1946

BUREAU V R

Evidence for change of year of birth of deceased is shown on MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore 13-2

# CERTIFICATE OF DEATH

★ Reg. Dist. No. 32

FILM No. 101 MAY - 2 1946

## 1. PLACE OF DEATH:

County Balto.  
City or town Brooklandville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 yr.  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Balto.  
City or town Brooklandville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Isaac Lobe Strauss  
(If rural, give LOCATION)  
2.(a) If veteran, name war

## 3. (a) FULL NAME

JOHN COOPER DORSEY

## 3. (b) Social Security Number

unknown

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Marjorie W. Dorsey

6. (c) If alive, give age 48 years  
7. Birth date of deceased (mo., day, yr.) April 20 - 1896 - 1894

8. AGE: Years 52 Months 1 Days 1 If less than one day hrs. min.

9. Birthplace Carroll Co. Md.  
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Frank W. Dorsey

13. Birthplace Howard Co. Md.

14. Maiden name Elena S. Ritter

15. Birthplace Harford Co. Maryland

16. Informant Marjorie Minnie Dorsey

Address Brooklandville, Maryland

17. Burial Date thereof April 25 - 46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Druid Ridge

Location Pikeville, Maryland

18. Funeral director Frank A. Newell

Address Pikeville, Maryland

19. MARY-46 E. E. Nichols  
(Date rec'd by Registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 1946 at 3:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2, 1946 to April 23, 1946  
and that I last saw him alive on April 17, 1946

Immediate cause of death

Pulmonary tuberculosis

Due to Pulmonary tuberculosis 2 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A. Adams  
M. D. or other

Address 1413 Federation Rd, Pikeville Date signed 4/22/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
APR 26 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of name of town where death occurred is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

03488

FILM No. I O 1 APR 15 1946

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

### 1. PLACE OF DEATH:

County Balto  
City or town White Marsh  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Box 110 Ebenezer Rd.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Balto

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 110 Ebenezer Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name War

### 3. (a) FULL NAME

Frank H. Drayer.

### 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

M W married

6.(b) Name of husband or wife Alice (Bender)

7. Birth date of deceased (mo., day, yr.) April 13 - 1896 6.(c) If alive, give age years

8. AGE: Years 47 Months Days If less than one day  
.....hrs. ....min.

9. Birthplace Balto. Co.  
(Town, county, and state)

10. Usual occupation mechanic, refrigerator

11. Industry or business Garage Operator

12. Name Henry Drayer

13. Birthplace Balto. Co.

14. Maiden name Elizabeth Curice

15. Birthplace Balto.

16. Informant Alice Drayer (wife)

Address Box 110 Ebenezer Rd.

17. (Burial, cremation, or removal, Which?) Burial Date thereof 4/10/46  
(month) (day) (year)

Cemetery or crematory Holy Redeemer

Location Delair Rd.

18. Funeral director John W. Connelly

Address 418 Eastern Ave. Box 21.

19. 4/9/46 John W. Connelly  
(Date rec'd by registrar) (Signature) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 19 46 at 1 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 25 19 42 to April 6 19 46  
and that I last saw him alive on April 6 19 46

Immediate cause of death

Coronary Thrombosis

DURATION

2 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. J. Miller MD

M. D. or other

Address Ridge Rd Box 6 Date signed 4/8/46

RECEIVED  
APR 10 1946  
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03489

P

Reg. Dist. No. *1st*

<b>1. PLACE OF DEATH</b> County..... <u>Baltimore</u> City or town..... <u>Fort Howard;</u> (If outside city or town limits, write RURAL and give nearest town) <u>54 days</u> How long in above place of death? Hospital, institution, or street address where death occurred: <u>Fort Howard, Md, Vets Adms.</u> How long in hospital or institution? <u>54 Days</u>			<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Dorchester</u> City or town..... <u>Cambridge</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>219 West End Ave.</u> (If rural, give LOCATION) 2.(a) If veteran, name war <u>World War I</u>		
<b>3. (a) FULL NAME</b> <u>James G. Drumm</u>			<b>3. (b) Social Security Number</b>		
<b>4. Sex</b> <u>White</u>	<b>5. Color or race</b> <u>Male</u>	<b>6. (a) Single, married, widowed, or divorced</b> <u>Divorced</u>			
<b>6. (b) Name of husband or wife</b>					
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>6-9-98</u>					
<b>8. AGE:</b> Years <u>47</u> Months <u>10</u> Days <u>12</u> If less than one day _____ hrs. _____ min.					
<b>9. Birthplace</b> <u>Maryland</u>					
<b>10. Usual occupation</b> <u>Dry Cleaner</u>					
<b>11. Industry or business</b>					
FATHER	<b>12. Name</b> <u>Charles Drumm</u>				
	<b>13. Birthplace</b> <u>Penn.</u>				
MOTHER	<b>14. Maiden name</b> <u>Ida D. Brown</u>				
	<b>15. Birthplace</b> <u>Delaware</u>				
<b>16. Informant</b> <u>Clinical Records, Vets. Adms. Hosp.</u> Address <u>Fort Howard, Maryland</u>					
<b>17. Burial</b> <u>Odd Fellows Cemetery</u> Date thereof <u>4/24/46</u> (Burial, cremation, or removal, Which?) (month) (day) (year) Cemetery or crematory <u>Seaford, Del.</u> Location _____					
<b>18. Funeral director</b> <u>Kenneth Thomas</u> Address <u>Cambridge, Md.</u>					
<b>19. 422</b> <u>19 46</u> <u>April 21</u> (Date rec'd by registrar) Registrar					
<b>MEDICAL CERTIFICATION</b> <b>20. DATE OF DEATH</b> <u>April 21</u> 19 <u>46</u> at <u>6:15</u> A.M. <b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>2-26-46</u> to <u>4-21-46</u> im alive on <u>4-21-46</u> and that I last saw h. _____ Immediate cause of death <u>CARCINOMA: ADENO. CARDIAC END</u> <u>OF THE STOMACH WITH METASTASIS</u> Due to _____ Due to _____ Other conditions <u>Anemia, Secondary to (1)</u> (Include pregnancy within 3 months of death) Major findings of operations _____ Date of op. _____ Autopsy results _____ PHYSICIAN: Please underline the cause to which death should be charged statistically.					
<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____					
<b>23. SIGNATURE</b> <u>Robert M. Cullison</u> <u>R. M. CULLISON, MD. ACTING CLIN. DIR.</u> Address _____ Date signed _____					



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 03490

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)Now long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

607 Hilton Ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 607 Hilton Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

None

## 3. (a) FULL NAME

Hedwig Anna Embury

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Married6.(b) Name of husband or wife Percy C. Embury7. Birth date of deceased (mo., day, yr.) Feb. 19, 1890 6.(c) If alive, give age \_\_\_\_\_ years8. AGE: Years 56 Months 1 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.8. Birthplace Baltimore, Balto. Co., Md.  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name George J. Emperle13. Birthplace Germany14. Maiden name Hedwig Wisse15. Birthplace Germany16. Informant Percy C. EmburyAddress 607 Hilton Ave. Catonsville17. Burial Date thereof Apr 6, 1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Landon ParkLocation Baltimore, Md.18. Funeral director Easton SonsAddress 608 Frederick Ave. Catonsville19. 4-5 19 46 Harold Miller  
(Date rec'd by registrar) (year) (signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 3, 1946 at 9:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8, 1946 to April 3, 1946 and that I last saw h.e. alive on April 3, 1946

Immediate cause of death

Coronary Thrombosis

DURATION

UnknownDue to Coronary Artery SclerosisUnknownDue to Hypertensive Cardio-vascular diseaseUnknownOther conditions Diabetes MellitusUnknown

(Include pregnancy within 8 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

M. L. Sugawell M.D.

M. D. or other

Address 1109 St Paul St Date signed April 3, 1946  
Baltimore Md

RECEIVED  
APR 8 1946  
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 490

## CERTIFICATE OF DEATH

Reg. Dist. No. 03491 44

## 1. PLACE OF DEATH:

County... Balto.  
 City or town... Sparsburg Point  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 58 yrs.  
 Hospital, institution, or street address where death occurred:  
2000 Sp. Pt. Rd.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... md. County... Balto.  
 City or town... Sparsburg Point  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2000 Sp. Pt. Rd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Cora Lee Eppard

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Ernest L. Eppard  
 6. (c) If alive, give age 63 years  
 7. Birth date of deceased (mo., day, yr.) Jan. 25 - 1885  
 8. AGE: Years 61 Months 3 Days 0 If less than one day  
 9. Birthplace Virginia  
 (town, county, and state)  
 10. Usual occupation labour  
 11. Industry or business Rheems mfg. Co.  
 12. Name stream media  
 13. Birthplace Va.  
 14. Maiden name unmarried  
 15. Birthplace

16. Informant Arthur L. Eppard  
 Address 1718 North Bone Rd. Balto. 19  
 17. Burial Burial Date thereof April 27-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematorium Oak Lawn  
 Location Eastern Blvd.  
 18. Funeral director John G. Connolly  
 Address 416 Eastern Ave. Essex  
 19. Apr. 26 19. 46 John G. Connolly  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 19. 46 at 2:20 P.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 15 19. 46 to April 25 19. 46  
 and that I last saw him alive on April 24 19. 46

Immediate cause of death Cerebral thrombosis  
 Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Richard M. J. M. D. or other  
 Address 520 D St. Sp. Pt. 19 Date signed 4.25.46

12150

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

RECEIVED  
APR 27 1946  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

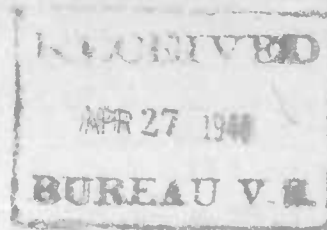
2411 N. Charles St., Baltimore 98-2

## CERTIFICATE OF DEATH

03492

Reg. Diat. No. 44

<b>1. PLACE OF DEATH:</b> County..... <u>Baltimore</u> City or town..... <u>Middle Trist section</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>7 years.</u> Hospital, institution, or street address where death occurred: <u>Route 13, Box 297 H, Balt. 21. Md.</u> How long in hospital or institution?.....				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Baltimore</u> City or town..... <u>Middle Trist section</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>Route 13, Box 297 H Balt. 21. Md.</u> (If rural, give LOCATION) 2.(a) If veteran, name war..... <u>W</u>			
<b>3. (a) FULL NAME</b> <u>Ada M. Erich</u>				<b>3. (b) Social Security Number</b> <u>none</u>			
<b>4. Sex</b> <u>7.</u>		<b>5. Color or race</b> <u>W</u>		<b>6. (a) Single, married, or divorced</b> <u>Married</u>			
<b>6. (b) Name of husband or wife</b> <u>George B. Erich</u>				<b>6. (c) If alive, give age</b> <u>68</u> years			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>2 12 - 1881</u>							
<b>8. AGE:</b> Years <u>65</u>		Months <u>2</u>		Days <u>14</u>		If less than one day .... hrs. .... min.	
<b>9. Birthplace</b> <u>Baltimore Md.</u> (Town, county, and state)							
<b>10. Usual occupation</b> <u>House wife</u>							
<b>11. Industry or business</b> <u>Otis P. Thompson</u>							
<b>FATHER</b>		<b>12. Name</b> <u>unknown</u>					
<b>MOTHER</b>		<b>13. Birthplace</b> <u>unknown</u>					
<b>14. Maiden name</b> <u>unknown</u>		<b>15. Birthplace</b> <u>George B. Erich</u>					
<b>16. Informant</b> <u>Route 13, Box 297 H, Balt. 21. Md.</u>							
<b>17. Burial</b> (Burial, cremation, or removal. Which?) Date hereof <u>4/29/46</u> (month) (day) (year) Cemetery or crematory <u>Baltimore</u> Location <u>Eastern Ave Balt. Md.</u>							
<b>18. Funeral director</b> <u>Wm. J. J. J. J.</u> Address <u>127 St Paul St. Balt. 2. Md.</u>							
<b>19.</b> <u>4/27</u> 19 <u>46</u> <u>a.w. Hedrich</u> (Date rec'd by registrar) Registrar							
<b>MEDICAL CERTIFICATION</b> <b>20. DATE OF DEATH</b> <u>April 26</u> 19 <u>46</u> at <u>10:00 PM</u> <b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>Jan 2</u> 19 <u>46</u> to <u>April 26</u> 19 <u>46</u> and that I last saw him alive on <u>April 26</u> 19 <u>46</u> Immediate cause of death <u>Central Hemorrhage</u> Due to <u>Hypertensive Heart Disease</u> Due to..... Other conditions..... (Include pregnancy within 3 months of death) Major findings of operations..... Date of op. .... Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.							
<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?..... <b>23. SIGNATURE</b> <u>Samuel M. Hummel</u> <u>Erie Md</u> M. D. or other Address..... Date signed <u>4/24/46</u>							





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03493

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Mount Wilson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 0 yrs., 0 mos., 10 days  
 Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium  
 How long in hospital or institution: 0 yrs., 0 mos., 10 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2520 Greenmount Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Howard T. Faulkner

## 3.(b) Social Security Number

No. Unknown

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	---

6.(b) Name of husband or wife Mary E. Faulkner  
 6.(c) If alive, give age 53 years  
 7. Birth date of deceased (mo., day, yr.) August 7, 1888  
 8. AGE: Years 57 Months 8 Days 10 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Centerville, Maryland  
 (Town, county, and state)  
 10. Usual occupation Salesman  
 11. Industry or business \_\_\_\_\_  
 12. Name Nelson C. Faulkner  
 13. Birthplace Caroline Co., Maryland  
 14. Maiden name Mary J. Carroll  
 15. Birthplace Hoopers Island, Maryland

16. Informant Howard T. Faulkner  
 Address 2520 Greenmount Ave., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof April 20, 1946  
 (month) (day) (year)  
 Cemetery or crematory Greenmount Cemetery  
 Location Hillsboro, Maryland

18. Funeral director John O. Mitchell & Sons  
 Address 1900 Eutaw Place, Balto., Md.

19. April 17, 1946 Earl T. Webster  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 17, 1946 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7, 1946 to April 17, 1946  
 and that I last saw him alive on April 17, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 3 Yrs.

Due to Tubercle Bacilli

Due to \_\_\_\_\_

Other conditions Fatal Pulmonary Hemorrhage  
 (Include pregnancy within 3 months of death)

Major findings of operations No operation Date of op. \_\_\_\_\_

Autopsy results No autopsy  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Stewart S. Shaffer M.D. M. D. or other \_\_\_\_\_  
 Address Mount Wilson, Md. Date signed 4/17/46

Rec'd 4-19-46 Dr. E. E. Nichols

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APR 22 1946

BUREAU V.B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 03494 38

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Towson 4, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5-236 Linden Heights Ave  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Helen R. Annunzio FRANZ

## 3. (b) Social Security Number

220-18-7741

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23, 1922

8. AGE: Years 23 Months 5 Days 4 If less than one day  
 hrs. min.

9. Birthplace Baltimore, Md.  
(Town, county, and state)10. Usual occupation Secretary

11. Industry or business

12. Name I. C. Franz13. Birthplace Germany14. Maiden name Anna Hickey15. Birthplace Springfield, Mass.

Personal History- Hospital Records

16. Informant Eudowood Sanatorium, Towson 4, Md.17. Burial Date thereof 4-30-46  
(Burial, cremation, or removal? Which?) (month) (day) (year)Cemetery or crematory Lorraine CemeteryLocation Baltimore, Maryland18. Funeral director Spring BucksAddress 5005 Park Heights Ave19. 4/29 46 A. W. Redner  
(Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 19 46, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 19 46 to April 27 19 46  
 and that I last saw him alive on April 26 19 46

Immediate cause of death Pulmonary T.B. DURATION 4 yr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. A. Bridges M. D. or otherAddress Towson 4, Maryland Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03495 30  
Reg. Dist. No.

### 1. PLACE OF DEATH:

County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 yrs  
Hospital, institution, or street address where death occurred:  
City Home  
How long in hospital or institution? 4 mo.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 216 Bloomsbury Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war None

### 3. (a) FULL NAME

Frank Bushey Gallion

### 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife May Gallion 6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1868

8. AGE: Years 78 Months 2 Days 13 If less than one day hrs. min.

9. Birthplace Howard Co Md.  
(Town, county, and state)

10. Usual occupation Farmer - Retired

11. Industry or business George F. Gallion

12. Name George F. Gallion

13. Birthplace Frederick Co, Md.

14. Maiden name Annie M. Bushey

15. Birthplace Frederick Co, Md.

16. Informant Mrs. May Gallion

Address 216 Bloomsbury Ave. Catonsville

17. Burial Date thereof Apr 8, 1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Int. View Cem.

Location Slacks Corner, Md.

18. Funeral director E. Astor Jones

Address 608 Frederick Ave. Catonsville

19. 4-8 1946 Harriet Miller  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 6, 1946 at 11:46 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 April 1946, to 5 April 1946

and that I last saw him alive on 5 April 1946

Immediate cause of death Myocardial failure DURATION Unknown

Due to Generalized arterio

sclerosis with cardio

Due to vascular renal

disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Anteopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Stephen Lee Magness MD M. D. or other

Address 752 Frederick Ave. Date signed 7 April 46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

30280

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED  
APR 9 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

## 4211 N. Charles St., Baltimore

### CERTIFICATE OF DEATH

03496

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Towson 4, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Since Oct 13, 1945  
 Hospital, institution, or street address where death occurred:  
Eudowood Sanatorium, Towson 4, Md.  
 How long in hospital or institution? Since Oct 13, 1945

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore City  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3409 Foster Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Anne May Gifford

## 3. (b) Social Security Number

4. Sex Female 5. Color of face White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Sept 17, 1912  
 8. AGE: Years 33 Months 6 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore Md  
 (Town, county, and state)  
 10. Usual occupation Practical Nurse  
 11. Industry or business Gifford + Gump Pratt Hosp.  
 12. Name Walter Gifford  
 13. Birthplace Maryland - Baltimore  
 14. Maiden name Anne Jones  
 15. Birthplace Baltimore Md

## Personal History-Hospital Records

16. Informant Eudowood Sanatorium, Towson 4, Md.  
 Address Eudowood Sanatorium, Towson 4, Md.

17. Burial Date thereof 4/6/46  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory New Cathedral Cemy.

Location Ford Ave. Balt. Md.

18. Funeral director John O. Mitchell & Sons Inc.

Address 1900 Eutaney Place

19. April 4 19 46  
 (Date rec'd by registrar) Registrar W. A. Bridges

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 19 46 at 3:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 15 19 45 to April 4 19 46  
 and that I last saw her alive on April 3 19 46

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Pulmonary tuberculosis Onset March 1944  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. A. Bridges M. D. or other \_\_\_\_\_

Address Towson 4, Md. Date signed \_\_\_\_\_



80384

RECEIVED

MAY 3 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03497

P

Reg. Dist. No.

30

## 1. PLACE OF DEATH:

County Balto.City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Opitz Home - Edmondson Ave. & Nunnery Lane

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Arbutus  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4400 Leeds Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

GEORGE HENRY GLEIM

## 3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife Gesina Gleim

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

March 22, 1864

8. AGE:

Years

Months

Days

If less than one day

82

0

18

hrs.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Meat Packer (Own Business)

FATHER

12. Name

Nicholas Gleim

13. Birthplace

Hessen, Germany

MOTHER

14. Maiden name

Elizabeth Meyer

15. Birthplace

Germany16. Informant Mrs. Katherine Reid

Address

4400 Leeds Ave., Arbutus17. Burial  
(Burial, cremation, or removal. Which?)

Date thereof

4/12/46

(month) (day) (year)

Cemetery or crematory

Louison Park Cem.

Location

Balto. Md.

18. Funeral director

Wm. J. Dickerson & Son

Address

North and Beaman Ave.19. 4/11  
(Date rec'd by registrar)19 46A.W. Hefner

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1946 at 8:30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 2, 1945 to April 10, 1946  
and that I last saw him alive on April 9, 1946

Immediate cause of death

Generalized arteriosclerosis  
Heart block

DURATION

3 yrs3 yrs

Due to

Bilateral Arteriosclerotic Gangrene 2 mos

Due to

7 feet  
Heart failure with edema 2 mos

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 4001 Wilkens Ave Date signed 4-11-46

# STATE OF MARYLAND—CERTIFICATE OF DEATH

03498

## 1. PLACE OF DEATH

County Baltimore Registration Dist. No. 41  
 Village or City Fort Howard No. Veterans Adm. Hospital St.  Ward   
 Length of residence in city or town where death occurred 4 Minutes (If death occurred in a hospital or institution, give its NAME instead of street and number)  
 yrs.  mos.  ds.  How long in U.S. if of foreign birth? yrs.  mos.  ds.

## 2. FULL NAME HENRY L. HAMM

(a) Residence: No. 2001 Maryland Ave., Balto., Md. Ward.   
 (Usual place of abode) If nonresident give city or town and State

### PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>	
5a. If married, widowed, or divorced HUSBAND of <u>Mrs. Dorothy Hamm</u> (or) WIFE of <u></u>			
6. DATE OF BIRTH (month, day, and year) <u>1-12-1910</u>			
7. AGE Years <u>36</u>	Months <u>3</u>	Days <u>12</u>	If LESS than 1 day, <u></u> hrs. or <u></u> min.
8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Shipping Clerk</u>		9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. <u></u>	
10. Date deceased last worked at this occupation (month end year) <u></u>		11. Total time (years) spent in this occupation <u></u>	

12. BIRTHPLACE (city or town) Virginia  
 (State or country)

13. NAME William Hamm

14. BIRTHPLACE (city or town) North Carolina  
 (State or country)

15. MAIDEN NAME Regina Whorley

16. BIRTHPLACE (city or town) Virginia  
 (State or country)

17. INFORMANT Clinical Records, Vets. Adm. Hosp.  
 (Address) Ft. Howard, Maryland

18. BURIAL, CREMATION, OR REMOVAL  
 Place Petersburgh, Va. Date , 19

19. UNDERTAKER Oder Funeral Home, Inc.  
 (Address) 4644 York Rd., Balto., Md.

20. FILED 5/11/46 Wm. L. Hamm  
 Registrar

### MEDICAL CERTIFICATE OF DEATH

#### 21. DATE OF DEATH

(Month) April (Day) 22, 1946 (Year)

22. I HEREBY CERTIFY, That I attended deceased from  
April 22, 1946, to April 22, 1946

I last saw him alive on April 22, 1946; death is said  
 to have occurred on the date stated above, at 9:30 P.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance  
 were as follows:

Subdural hemorrhage with  
generalized arteriosclerosis

Date of onset

Unknown

Other Contributory Causes of importance:

Name of operation  Date of   
 What test confirmed diagnosis? Autopsy Was there an autopsy? Yes

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?  Date of injury , 19

Where did injury occur?

(Specify city or town, county and State)  
 Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify Unknown

(Signed) Wm. L. Hamm M.D. M. D.

(Address) Reg. Med. Officer, Veterans Adm. Hosp.

MARGIN RESERVED FOR BINDING

V.S. No. 1

IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927
Other contributory causes of importance:	
Gallstones	May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago
Other contributory causes of importance:	
Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

3499-4

## 1. PLACE OF DEATH

County BaltimoreVillage or City Sparrows PointRegistration Dist. No. 1702 Bleecher St. Ward 1stLength of residence in city or town where death occurred 2 yrs. 2 mos. 0 ds. How long in U. S. if of foreign birth? 0 yrs. 0 mos. 0 ds.

## 2. FULL NAME

(a) Residence: No. Dyke Na. Green St. Co Ward.

(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Marion Gertrude6. DATE OF BIRTH (month, day, and year) Oct 5 / 18867. AGE Years 79 Months 6 Days 2 If LESS than 1 day, 0 hrs. 0 min.8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Chimney Sweeper9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Farmer10. Date deceased last worked at this occupation (month and year) Retired 11. Total time (years) spent in this occupation Retired12. BIRTHPLACE (city or town) Green Co. Va. (State or country)13. NAME Robert Hamm14. BIRTHPLACE (city or town) Mary Va. (State or country)15. MAIDEN NAME Mary Douglas16. BIRTHPLACE (city or town) Green Co. Va. (State or country)17. INFORMANT Edward H. Hamm(Address) 2405 Fairway Drive

18. BURIAL, CREMATION, OR REMOVAL

Place Elkton Va. Date 4. 10, 194619. UNDERTAKER John C. Miller(Address) 2405 Fairway Drive20. FILED 4876 1946

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

April 7, 19346  
(Month) (Day) (Year)22. I HEREBY CERTIFY That I attended deceased from Apr 7, 1946, to Apr 7, 1946I last saw him alive on Apr 7, 1946; death is said to have occurred on the date stated above, at 0 m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Coronary occlusion

Date of onset

Immediate

Other Contributory Causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 1946

Where did injury occur? \_\_\_\_\_

(Specify city or town, county and State)  
Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?

If so, specify \_\_\_\_\_

(Signed) Dr. J. M. B. M.D.(Address) Dr. J. M. B. M.D.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 520

## CERTIFICATE OF DEATH

03500  
Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltoCity or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

905 Oakley Beach Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltoCity or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)Street No. 905 Oakley Beach Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Robert Roy Harrison

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

8. (b) Name of husband or wife

Eula VishawonHarrison

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

April 24 - 1888

8. AGE:

Years

Months

Days

If less than one day

☒59

hrs.

min.

9. Birthplace

Va.

(Town, county, and state)

10. Usual occupation

Tool crib

11. Industry or business

Rheums

MOTHER FATHER

12. Name

Taylor Harrison

13. Birthplace

Va.

14. Maiden name

Ann Harrison

15. Birthplace

Va.

16. Informant

Mrs. Eula Harrison (wife)

Address

905 Oakley Beach Ave.17. Cremation

(Burial, cremation, or removal. Which?)

Date thereof

7/23/46  
(month) (day) (year)

Cemetery or crematory

Loudon Pk.

Location

Frederick Rd.

18. Funeral director

John W. Connelly

Address

418 Eastern Ave. Elex 21.19. 4/2/46

(Date rec'd by registrar)

19 46John W. Connelly

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1946 at 6:30 PM21. I CERTIFY that death occurred on the date above stated - that I attended deceased from  
Jan 15 1946 to April 19 1946  
and that I last saw him alive on April 18 1946

Immediate cause of death

Carcinoma kidney - R

DURATION

? hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John W. Connelly

M. D. or other

Address

520 St. John St.

Date signed

2/2/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 24 1966

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74a

## CERTIFICATE OF DEATH

Reg. Dist. No. 03501 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 months, 9 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 2 months, 9 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3633 Greenmount Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Edward Hart

## 3.(b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife \_\_\_\_\_  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) September 5, 1909  
 8. AGE: Years 36 Months 7 Days 24 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)  
Paper hanger  
 10. Usual occupation \_\_\_\_\_  
 11. Industry or business For himself  
 12. Name Edward L. Hart  
 13. Birthplace Virginia  
 14. Maiden name Annie Trader  
 15. Birthplace Virginia

16. Informant Hospital Records  
 Address Catonsville 28, Maryland  
 17. Funeral Date thereof 3/24/46  
 (Burial, cremation, or removal) Which? (month) (day) (year)  
 Cemetery or crematory Baltimore  
 Location Spring Grove State Hospital  
 18. Funeral director William G. Gandy  
 Address 1217 H. Bond  
 19. 5/1 19 46 A. W. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 29, 19 46, at 1:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_  
 and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_  
Coronary occlusion  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Sudden death  
Injury  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Dr. M. Kieffer Step. Med.  
1010 Lehigh Ave. M. D. or other \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed 4-29-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03502

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year, 8 months, 15 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 1 year, 8 months, 15 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....  
 City or town..... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 725 South Bond Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3.(a) FULL NAME

Joseph Hayden

## 3.(b) Social Security Number

4. Sex..... male  
 5. Color or race..... white  
 6.(a) Single, married, widowed, or divorced..... single  
 6.(b) Name of husband or wife.....  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... June 22, 1860  
 8. AGE: Years..... 85 Months..... 10 Days..... 13  
 If less than one day..... hrs. .... min.

9. Birthplace..... Brooklyn, New York  
 (Town, county, and state)  
 10. Usual occupation..... Marble worker (retired)  
 11. Industry or business..... Marble  
 12. Name..... Thomas Hayden  
 13. Birthplace..... Ireland  
 14. Maiden name..... Catherine Boyle  
 15. Birthplace..... Ireland

16. Informant..... Hospital records  
 Address..... Catonsville-28, Maryland  
 17. Buried..... Date thereof..... May 10, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Spring Grove State Hospital  
 Location..... Catonsville 28, Maryland  
 18. Funeral director..... Spring Grove State Hospital  
 Address..... Catonsville 28, Maryland

19. 5-10 19 46  
 (Signature of registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 4 19 46 at 8:45 a.m.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
July 20 19 44 to April 4 19 46  
 and that I last saw him alive on..... 19.....  
 Immediate cause of death.....

Broncho pneumonia, bilateral  
Pulmonary tuberculosis  
 Due to.....  
 Due to.....  
 Other conditions.....

## DURATION

2 days  
Indefinite

(Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....  
 Autopsy results..... as above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of Injury Injured at work?

23. SIGNATURE..... Isadore Tuerk, M.D.  
 M. D. or other  
 Address..... Catonsville-28, Maryland Date signed..... 5-9-46

50380

23000

RECEIVED

MAY 13 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1342

## CERTIFICATE OF DEATH

Reg. Dist. No. 035032

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Opitz Home

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. unknown  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

William J. Hayes

## 3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>
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6. (b) Name of husband or wife --6. (c) If alive, give age -- years7. Birth date of deceased (mo., day, yr.) June 30, 1874

8. AGE:	Years	Months	Days	If less than one day
<u>71</u>	<u>9</u>	<u>19</u>	<u>hrs.</u>	<u>min.</u>

9. Birthplace Pa.  
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

FATHER	12. Name <u>Michael Hayes</u>
	13. Birthplace <u>Ireland</u>

MOTHER	14. Maiden name <u>Margaret Wright</u>
	15. Birthplace <u>Ireland</u>

16. Informant E. D. Laughlin  
Address 3310 W. Liberty Ave., Pittsburgh17. Removal Date thereof 4/19/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Calvary Cem.  
Pittsburgh, Pa.18. Funeral director WM. J. TICKNER & SONS  
Address Baltimore, Md.19. 4-19-46 Harold M. Miller  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 19 19 46, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 10 19 46 to Apr 19 19 46  
and that I last saw him alive on Apr 19 19 46

Immediate cause of death

Hypertensive Cardio Vasc  
Cerebral Blood Vessels

DURATION

1 yr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) Pa (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Baltimore Date signed 4-19



RECEIVED

APR 22 1946

BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH: BALTO Co  
County.....  
City or town.....HALETHROPE - 27  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 35 yrs.  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State.....MD County.....BALTO Co  
City or town.....HALETHROPE - 27  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....4712 WASH BLVD  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME  
MARGARET HELBIG

3. (b) Social Security Number

4. Sex.....F 5. Color or race.....W 6.(a) Single, married, widowed, or divorced.....WIDOWED  
6.(b) Name of husband or wife.....O. RICHARD HELBIG (DEAD)  
6.(c) Name give age.....H years  
7. Birth date of deceased (mo., day, yr.).....JULY 26 - 1862  
8. AGE: Years.....93 Months.....9 Days.....If less than one day.....hrs.....min.

9. Birthplace.....GERMANY  
(Town, county, and state)

10. Usual occupation.....HOUSEWIFE

11. Industry or business

FATHER 12. Name.....JOHN KLAUSMANN  
13. Birthplace.....GERMANY

MOTHER 14. Maiden name.....  
15. Birthplace.....GERMANY

16. Informant.....MRS ROSE OBST  
Address.....4712 WASH BLVD

17. Burial.....BURIAL Date thereof.....5, 4- 46  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory.....LONDON PK.  
Location.....CITY.

18. Funeral director.....JOHN R KENNY  
Address.....1242 LEONTER. HALETHROPE 27

19. 5/3 1946 X 6 A. W. Hedrick  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....April 30 1946 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1945 to April 30 1946 and that I last saw him alive on April 29 1946

Immediate cause of death.....Drowning.....DURATION.....12 H

Due to.....Drowning.....

Due to.....General debility.....

Other conditions.....Old age

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....E. S. M... M.D. or other

Address.....56 Baltimore Date signed.....5-2-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Bacon  
Taylor Avenue

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 0350538

### 1. PLACE OF DEATH:

County Carney  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 15 years  
Hospital, institution, or street address where death occurred:  
Harford Road & Edwards Ave.  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carney  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Harford Road & Edwards Avenue  
(If rural, give LOCATION)  
2(a) If veteran, name war

### 3. (a) FULL NAME

Hilda Herr

### 3. (b) Social Security Number

4. Sex <u>female</u>	5. Color or race <u>white</u>	6. (a) Single, married, widowed, or divorced <u>married</u>	
6. (b) Name of husband or wife <u>Charles Herr, Jr.</u>			
7. Birth date of deceased (mo., day, yr.) <u>Feb. 16, 1890</u>			
8. AGE: <u>56</u>	Years <u>1</u>	Months <u>23</u>	Days <u>hrs. min.</u>
9. Birthplace <u>Germany</u> (Town, county, and state)			
10. Usual occupation <u>At home</u>			
11. Industry or business			
FATHER	12. Name <u>?</u>		
	13. Birthplace <u>?</u>		
MOTHER	14. Maiden name <u>?</u>		
	15. Birthplace <u>?</u>		

16. Informant Mr. Charles Herr, Jr.  
Address Harford Road & Edwards Avenue  
17. Burial Date thereof 4/10/46  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Parkwood  
Location Baltimore  
18. Funeral director Leonard J. Ruck  
Address 5305 Harford Road 14  
19. 4/9 19 46 A. M. Bacon  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 8th, 19 46, at 5:30 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935 to Apr 8 19 46 and that I last saw him alive on Jan. 23 19 46.  
Immediate cause of death Coronary occlusion  
Due to Chronic myocarditis  
Hypertension  
Due to  
Other conditions Coronary occlusion 1935 6 wks.  
(Include pregnancy within 8 months of death)  
Major findings of operations  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
A. M. Bacon, M.D. by permission  
of Pollie C. Hudson, M.D. - D.M.E.  
23. SIGNATURE M. D. or other  
Address 2810 Taylor Ave. Date signed 4/9/46

### DURATION

first  
minutes  
11 yrs  
11 yrs

RECEIVED

APR 11 - 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-6

03506

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year, 11 mos., 21 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 1 year, 11 mos., 21 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Harford  
 City or town..... Aberdeen  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. RFD#1  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Amelia Hitchcock

## 3. (b) Social Security Number

4. Sex..... female 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... married  
 6.(b) Name of husband or wife..... Charles Hitchcock  
 6.(c) If alive, give age..... 65 years  
 7. Birth date of deceased (mo., day, yr.)..... March 14, 1910  
 8. AGE: Years..... 36 Months..... - Days..... 20 If less than one day..... hrs. min.

9. Birthplace..... Havre de Grace, Maryland  
 (Town, county, and state)  
 10. Usual occupation..... Waitress  
 11. Industry or business..... Restaurant  
 12. Name..... Fred Zellman  
 13. Birthplace..... Germany  
 14. Maiden name..... Martha Mitchell  
 15. Birthplace..... Maryland

16. Informant..... Hospital record  
 Address..... Catonsville-28, Maryland  
 17. Burial Date thereof..... April 6/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Fresh Meadows  
 Location..... Harford Co Md  
 18. Funeral director..... Blair & Sons  
 Address..... Bell Co Md  
 19. 4-5 1946 Harry B. Miller  
 (by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 3 1946 at 5:30 PM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
April 13 1944 to April 3 1946  
 and that I last saw her alive on April 3 1946  
 Immediate cause of death..... Cachexia  
 DURATION..... 3 weeks  
 Due to..... General paresis Indef.  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results..... none  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of ..  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of Injury Injured at work?

23. SIGNATURE..... Isadore Tuerk, M.D. M. D. or other  
 Address..... Catonsville-28, Md. Date signed..... 4-4-46

RECEIVED  
APR 8 1968  
BUREAU OF  
A



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

03507

P

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Baltimore Co.City or town..... Chase Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md..... County..... BaltimoreCity or town..... Chase  
(If outside city or town limits, write RURAL and give nearest town)Street No..... Green Bank Road  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Delia Holland

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife..... Melvin Holland

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... November 11, 1873

8. AGE: Years Months Days If less than one day

72 4 25 ..... hrs. .... min.9. Birthplace..... Ireland  
(Town, county, and state)10. Usual occupation..... Housewife

11. Industry or business

12. Name..... ? Gradey13. Birthplace..... Ireland14. Maiden name..... Potter15. Birthplace..... Ireland16. Informant..... Melvin HollandAddress..... Green Bank Rd. Chase Md.17. Burial..... Date thereof..... 4-9-1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... CathedralLocation..... Baltimore Md.Funeral director..... Flynn & FlemingAddress..... 1426 Light Street

18. April 8 1946

(Date rec'd by registrar)

A. W. Hedrick

Registar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 5, 1946..... 19..... at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 1945 to April 5, 1946and that I last saw her alive on April 5, 1946Immediate cause of death..... CarcinomaLIVER

Due to.....

Carcinoma Breast

Due to.....

Other conditions..... Arteriosclerosis - GENHeart failure

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE..... Thomas Bruce Hargis M.D.

M. D. or other

Address..... 815 Eastern AveDate signed..... 6 Apr 46

DURATION

6 mos

3 yrs

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, MarylandHow long in hospital or institution? 3 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1019 Forrest St. Baltimore, Md.  
(If rural, give LOCATION)

2.(a) If veteran, name war

★ WW-2

## 3. (a) FULL NAME

LEREOY HOLLIDAY

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Alice Holliday6. (c) If alive, give age 36 years

7. Birth date of

deceased (mo., day, yr.)

1-26-00 (Jan. 26, 1900)

8. AGE:

Years

Months

Days

If less than one day

46226

hrs.

min.

9. Birthplace

Michigan

(Town, county, and state)

10. Usual occupation

Lather

11. Industry or business

FATHER

12. Name

Joseph Holliday

13. Birthplace

Michigan

MOTHER

14. Maiden name

Annie Wales

15. Birthplace

Canada

16. Informant

Clinical Records, Vets. Adm. Hosp.

Address

Fort Howard, Maryland

17.

Burial  
(Burial, cremation, or removal. Which?)

Date thereof

4/26/46  
(month) (day) (year)

Cemetery or crematory

National Cemetery.

Location

Baltimore, Maryland

18. Funeral director

Wm. Cook, Inc.

Address

1217 St. Paul St., Baltimore, Md.

19.

4/24 46  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 19 46, at 9:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 19, 19 46, to April 22, 19 46and that I last saw him alive on April 22, 19 46

Immediate cause of death

Pneumonia, lobar

DURATION

1 Day

Due to

Due to

Other conditions

Acute alcoholism

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert M. Cullison  
R.M. CULLISON, M.D. ACT. CLIN. DIR.

Address

Fort Howard, Maryland

Date signed

4-23-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 035030

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 months, 7 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 3 months, 7 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2709 Kennedy Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Joseph B. Jones

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed  
 6. (b) Name of husband or wife Ella G. Chaney  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) February 10, 1878  
 8. AGE: Years 68 Months 2 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)  
 10. Usual occupation Shipping clerk  
 11. Industry or business Shipping Sharp & Doherty  
 12. Name Charles W. Jones  
 13. Birthplace Baltimore, Maryland  
 14. Maiden name ?  
 15. Birthplace ?

16. Informant Hospital records  
 Address Catonsville-28, Md.  
 17. Burial Date thereof 4/15/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Balto.  
 Location " Md.  
 18. Funeral director William Cook Inc.  
 Address 1217 St. Paul St.  
 19. 4-13 19. 46 aw Hedrick  
 (State or city registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 19 46, at 9:25 a.m.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 4 19 46, to April 11 19 46  
 and that I last saw him alive on April 11 19 46

Immediate cause of death Terminal pneumonia DURATION 12 hours  
Arteriosclerotic cardio-vascular disease Indef.  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE Isadore Tuerk, M.D. M. D. or other  
 Address Catonsville-28, Md. Date signed 4-11-46

VS A15

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
County: <u>Baltimore</u>				(For newborn infants give residence of mother)			
City or town: <u>Catonsville</u> (If outside city or town limits, write RURAL and give nearest town)				State: <u>MD</u> County: <u>Baltimore</u>			
How long in above place of death?				City or town: <u>Catonsville</u> (If outside city or town limits, write RURAL and give nearest town)			
Hospital, institution, or street address where death occurred:				Street No. <u>4 Manning Lane</u> (If rural, give LOCATION)			
How long in hospital or institution?				2.(a) If veteran, name war			
3. (a) FULL NAME <u>William C Jones</u>				3. (b) Social Security Number			
4. Sex <u>Male</u>		5. Color of face <u>White</u>		6.(a) Single, married, widowed, or divorced <u>Widower</u>			
6.(b) Name of husband or wife <u>Emma S</u>				6.(c) If alive, give age _____ years			
7. Birth date of deceased (mo., day, yr.) <u>Jan 1870</u>							
8. AGE: Years <u>76</u>		Months <u>21</u>		Days <u>22</u>		If less than one day _____.hrs. _____min.	
9. Birthplace <u>Baltimore MD</u> (Town, county, and state)							
10. Usual occupation <u>Suburban Cook Retired</u>							
11. Industry or business							
12. Name <u>William C Jones</u>							
13. Birthplace <u>Baltimore MD</u>							
14. Maiden name <u>Elizabeth J Garrison</u>							
15. Birthplace <u>Baltimore MD</u>							
16. Informant <u>George E McJannet</u>							
Address <u>7687 E 36th</u>							
17. Burial, cremation, or removal. Which? <u>Burial</u>				Date thereof <u>4/9/46</u> (month) (day) (year)			
Cemetery or crematory <u>Linden Park</u>							
Location <u>Baltimore MD</u>							
18. Funeral director <u>William C Jones</u>							
Address <u>1214 St Paul St</u>							
19. Date rec'd by registrar <u>April 8 46</u>				Registrar <u>Wm. H. H. H.</u>			
				MEDICAL CERTIFICATION			
				20. DATE OF DEATH <u>April 6 1946</u> at <u>89</u>			
				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>April 4 1946</u> to <u>April 6 1946</u> and that I last saw him alive on <u>April 5 1946</u>			
				Immediate cause of death <u>Cerebral Thrombosis</u>		DURATION <u>Sudden</u>	
				Due to <u>Cardio-Vascular Disease</u>		<u>6 Months</u>	
				Due to			
				Other conditions			
				(Include pregnancy within 3 months of death)			
				Major findings of operations			
				Date of op.			
				Autopsy results			
				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
				22. VIOLENCE: If death was due to external causes, fill in the following:			
				Accident, suicide, or homicide			
				Where did injury occur? (City or town) (County) (State)			
				Injured at home, farm, industry, public place (where?)			
				Means of injury Injured at work?			
				23. SIGNATURE <u>Eliot W. Johnson MD</u> 3432 Frederick Ave. M. D. or other Date signed <u>4/16/46</u>			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of MARYLAND STATE DEPARTMENT OF HEALTH  
age & birth date of deceased is shown on 2411 N. Charles St., Baltimore B12

FILM No. I O 1 APR 29 1946

# CERTIFICATE OF DEATH

Reg. Dist. No. 37

## 1. PLACE OF DEATH:

County Baltimore  
City or town Texas  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution: Balto. Co. Home  
Stay in hospital or inst. (yrs., or mos., or days) 3 yrs. 7 mo. 6 da  
Stay in this community (yrs., or mos., or days) 3 yrs. 7 mo. 6 da

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Essey Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. \_\_\_\_\_ (If rural give LOCATION)  
2(a) IF VETERAN, NAME WAR \_\_\_\_\_

## 3. (a) FULL NAME

Mary Jordan

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Married  
6 (b) Name of husband or wife Charles Jordan  
6 (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) unknown March 10, 1860

8. AGE: Years 86 Months 4 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

12. Name Francis Coleman

13. Birthplace Maryland

14. Maiden name Ethel Hall

15. Birthplace Maryland

16. Informant Pector - St. Stephens Church

Address 1603 Eastern Ave. Essey, Md.

17. Burial Date thereof Apr. 11 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Stephens Cem

Location Essey, Md.

18. Funeral director Mrs. Robt. A. Elliott & Sons

Address 1129 N. Caroline St. Md.

19. April 1-8 1946 Wm J. Chilcoat  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 8 1946 at 7:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/2 1942 to Apr. 8 1946

and that I last saw him alive on 4/7 1946

Immediate cause of death Chronic Nephritis  
(-uramic Convulsions-)

DURATION

2 yrs.

Due to Arterio sclerosis

Due to Senility

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William C. Ensor M.D.

Address Cockeysville Md. Date signed 4/9/46

RECEIVED  
15 1944  
BUREAU V.R.

RECEIVED  
APR 15 1944  
BUREAU V.R.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4670

## CERTIFICATE OF DEATH

03512 30

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County Baltimore

City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Opitz Nursing Home

How long in hospital or institution?

5 Mo.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Baltimore - Rural  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 704 Old Home Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

### 3.(a) FULL NAME

KATE CATHERINE JOSLIN

### 3.(b) Social Security Number

no

#### 4. Sex

Female

#### 5. Color or race

white

#### 6.(a) Single, married, widowed, or divorced

widowed

### 6.(b) Name of husband or wife

George H. Joslin

6.(c) If alive, give age \_\_\_\_\_ years

#### 7. Birth date of

deceased (mo., day, yr.)

March 28, 1830

#### 8. AGE:

Years

83

Months

0

Days

27

If less than one day

hrs.

min.

#### 9. Birthplace

Baltimore, Maryland

(Town, county, and state)

#### 10. Usual occupation

Housewife

#### 11. Industry or business

#### FATHER

##### 12. Name

John Rheinhardt

##### 13. Birthplace

Baltimore, Maryland

#### MOTHER

##### 14. Maiden name

Unknown

##### 15. Birthplace

n

#### 16. Informant

Mr. Wilbur A. Joslin - son

Address

704 Old Home Rd.

#### 17.

Burial

Date thereof 4-29-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Loudon Park Cemetery

Location

Baltimore, Maryland

#### 18. Funeral director

HENRY SANDER & SONS, INC.

Address

NORTH AVE. & BROADWAY

#### 19.

(Date rec'd by registrar)

19

Registrar

### MEDICAL CERTIFICATION

#### 20. DATE OF DEATH

April 25

19

46 at 12:30 AM

#### 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 2

19

46 to Apr 25

19

and that I last saw him alive on

Apr 24

19

#### Immediate cause of death

Carcinoma of the Pancreas

#### DURATION

1 yr

Due to

Due to

Other conditions

Severe heart disease

(Include pregnancy within 3 months of death)

#### Major findings of operations

Date of op.

#### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

#### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

#### 23. SIGNATURE

M. D. or other

Address

Date signed

4-25

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

## CERTIFICATE OF DEATH

Reg. Dist. No. *3513* *xy*

## 1. PLACE OF DEATH

County *Baltimore*City or town *Middle River*  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *42 yrs*

Hospital, institution, or street address where death occurred:

*2120 Oakland Ave*

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County *Baltimore*City or town *Middle River*  
(If outside city or town limits, write RURAL and give nearest town)Street No. *2120 Oakland Ave*  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

*SARAH KAPLAN*

## 3. (b) Social Security Number

4. Sex

*FEMALE*

5. Color or race

*WHITE*

6. (a) Single, married, widowed, or divorced

*MARRIED*

6. (b) Name of husband or wife

*Louis*

8. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

*1884*

8. AGE:

Years

Months

Days

If less than one day

*62*

..... hrs. .... min.

8. Birthplace

*Russia*

(Town, county, and state)

10. Usual occupation

*Housewife*

11. Industry or business

12. Name

*Samuel*

13. Birthplace

*Russia*

14. Maiden name

*Reba Gita*

15. Birthplace

*Russia*

16. Informant

*Louis Kaplan*

Address

*2120 Oakland Ave*

17.

(Burial, cremation, or removal. Which?)

Date thereof

*4-5-46*  
(month) (day) (year)

Cemetery or crematory

*Hebrew Nursing Home*

Location

18. Funeral director

Address

*Face Lewis Inc*  
*1428 E. Balto. St*

19.

(Date rec'd by registrar)

19 *46**D. W. Hedrick*  
*Dist.*

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *APRIL 2 -* 19 *46*, at *12:17 P*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Sept 9*19 *43*to *APRIL 2*19 *46*and that I last saw him *ER* alive on *APRIL 1* 19 *46*

Immediate cause of death

*Cerebral Thrombosis*

DURATION

*60 hrs*

Due to

*Cerebral Arteriosclerosis**12 yrs*

Due to

Other conditions

*Diabetes mellitus**6 mo*

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

*Sh. Fuller*

M. D. or other

Address

*Ridge Road*Date signed *4/2/46*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

## CERTIFICATE OF DEATH

03514

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County Balto.City or town Towson  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

221 Regester Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State \_\_\_\_\_ County Balto.City or town Towson  
(If outside city or town limits, write RURAL and give nearest town)Street No. 221 Regester Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

JOHN W. KARFGIN

## 3. (b) Social Security Number

212-07-2628

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Virginia Turner Karfgin7. Birth date of deceased (mo., day, yr.) April 4, 1904

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years 42Months 0Days 19

If less than one day

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Balto., Md.  
(Town, county, and state)10. Usual occupation Insurance Broker11. Industry or business Poor-Bowen-Bartlett & KennedyFATHER 12. Name Chamens Karfgin, Sr.13. Birthplace Baltimore, Md.MOTHER 14. Maiden name Gertrude Esselman15. Birthplace Baltimore, Md.16. Informant Mr. Walter E. KarfginAddress 4331 Harford Rd.17. Burial Date thereof 4/25/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Western Cem.Location Balto., Md.18. Funeral director WM. J. TICKNER & SONSAddress Balto., Md.19. 4/24 19 46  
(Date rec'd by registrar)A. W. Hedrick  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 19 46 at 6:40 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 46 to April 23 1946  
and that I last saw him alive on April 23 1946

Immediate cause of death

Pulmonary Tuberculosis  
terminating in primary stage

DURATION

1941  
1946

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter E. Karfgin M. D. or other4331 Harford Rd Date signed 4/23/46

# STATE OF MARYLAND—CERTIFICATE OF DEATH

03515

P

## 1. PLACE OF DEATH

County Baltimore

Village or City Sparrows Point Md.

No. 709 East E

Registration Dist. No. 44

St. E Ward

Length of residence in city or town where death occurred 42 yrs.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

How long in U.S. if of foreign birth? yrs. mos. ds.

## 2. FULL NAME

(a) Residence: No. 709 East E St. E Ward.

(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5a. If married, widowed, or divorced HUSBAND or (or) WIFE of Sarah Edna

6. DATE OF BIRTH (month, day, and year) July 30/1873

7. AGE Years 72 Months 9 Days 17 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Water Tender  
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Beth Steel Co.  
10. Date deceased last worked at this occupation (month and year) 4/13/46 11. Total time (years) spent in this occupation 42 yrs.

12. BIRTHPLACE (city or town) Baltimore Md. (State or country)

13. NAME Thos M. Keys

14. BIRTHPLACE (city or town) Maryland (State or country)

15. MAIDEN NAME Don't know

16. BIRTHPLACE (city or town) Ind (State or country)

17. INFORMANT Mrs Sarah Keys (Address) 709 East Sparrows Pt

18. BURIAL, CREMATION, OR REMOVAL Place Mt Zion Cem Date April 17, 1946

19. UNDERTAKER Allen's Funeral Home (Address) 2008 Breckins St

20. FILED 4/15/46 A. W. Deduct Registrar.

## MEDICAL CERTIFICATE OF DEATH

### 21. DATE OF DEATH

April 13, 1946  
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from April 13, 1946, to 19, 1946

I last saw him alive on 19, 1946; death is said to have occurred on the date stated above, at 11 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Coronary Occlusion

Date of onset

2 hrs.

Other Contributory Causes of importance:

Hypertension

Name of operation None Date of None

What test confirmed diagnosis? None Was there an autopsy? Yes

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? None Date of injury None, 1946

Where did injury occur? None

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury None

Nature of injury None

24. Was disease or injury in any way related to occupation of deceased?

If so, specify None

(Signed) Dr. J. M. Capron M.D.

(Address) Dr. J. M. Capron

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1642)

## CERTIFICATE OF DEATH

03516 38  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County Baltimore  
City or town Towson 4 Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 9.22/1940 to 4/6/46  
Hospital, institution, or street address where death occurred:  
Eudowood Sanatorium, Towson 4, Md.  
How long in hospital or institution? 5 yrs. 7 mo. 13 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince George  
City or town Laurel  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1007 Montgomery st.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Carl Kidwell

## 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Henrietta Kidwell 6. (c) If alive, give age ..... years  
7. Birth date of deceased (mo., day, yr.) March 5, 1888.  
8. AGE: Years 58 Months 1 Days 1 If less than one day ..... hrs. .... min.  
9. Birthplace Virginia  
(Town, county, and state)  
10. Usual occupation Engineer  
11. Industry or business  
12. Name David Kidwell  
13. Birthplace West Virginia  
14. Maiden name Cornelia Lowrey  
15. Birthplace Virginia

16. Informant Personnel records-Hospital  
Address records Eudowood Sanatorium, Towson Md

17. Rural Date thereof 4-9-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory mt Lebanon  
Location Wanchester Va

18. Funeral director Rev. West Haulsman  
Address 4/6 Laurel Md

19. 4/6 (Date rec'd by registrar) 1/6 Registrar 4/6/46

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1946 at 7:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None 19..... to 19.....  
and that I last saw him alive on 19.....

Immediate cause of death Shot thru chest and heart. Suicide  
Depression  
Due to Pulmonary tuberculosis, advanced 19 33  
DURATION  
4/6/46

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Suicide Date of 4/6/46  
Where did injury occur? Towson Baltimore Md.  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) Hospital (Eudowood)  
Means of injury .32 revolver, suicide Injured at work? No

23. SIGNATURE Bollin C. Hudson MD. D.M.E.  
M. D. or other  
Address Towson Md Date signed 4/6/46



RECEIVED

MAY 3 1946

BUREAU V

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

03517

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Mount Wilson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 0 yrs., 2 mos., 10 days  
 Hospital, institution, or street address where death occurred: Mt. Wilson  
Branch, Md. Tuberculosis Sanatorium  
 How long in hospital or institution? 0 yrs., 2 mos., 10 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 618 Sligo Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Joseph H. Kirby

## 3. (b) Social Security Number

578-32-5633

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Ruth Kirby7. Birth date of deceased (mo., day, yr.) September 26, 18988. AGE: Years 47 Months 6 Days 15 If less than one day9. Birthplace Virginia (Town, county, and state)10. Usual occupation Fireman

11. Industry or business

12. Name Charles E. Kirby13. Birthplace Virginia14. Maiden name Rose B. Costello (?)15. Birthplace Unknown16. Informant Joseph H. KirbyAddress 618 Sligo Ave., Silver Spring, Md.17. Burial Date thereof April 15, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Burtonsville UnionLocation Burtonsville, Maryland18. Funeral director Warner E. Pumphrey Md.Address 8434 Georgia Ave., Silver Spring,19. April 10, 1946 Earl T. Webster

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1946 at 12:15 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 31, 1946 to April 10, 1946and that I last saw him alive on April 10, 1946Immediate cause of death Pulmonary TuberculosisDue to Tubercle BacilliOther conditions Tuberculous NephritisMajor findings of operations No operationAutopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Stewart S. Shaffer M.D.Address Mount Wilson, Md. Date signed 4/10/46

Recd. 4-12-46 Dr. E. E. Nichols

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 13 1941

BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 772

## CERTIFICATE OF DEATH

03519

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County BaltoCity or town Int. Wilson  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 daysHospital, institution, or street address where death occurred: Int. Wilson SanatoriumHow long in hospital or institution? Sanatorium

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_City or town \_\_\_\_\_  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Ilios. Klimick

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced unknown6.(b) Name of husband or wife Mary Klimick7. Birth date of deceased (mo., day, yr.) \_\_\_\_\_ 6.(c) If alive, give age \_\_\_\_\_ years8. AGE: Years about 47 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Chicago Ill.  
(Town, county, and state)10. Usual occupation Labr.11. Industry or business Int. Wilson Sanatorium12. Name Unknown13. Birthplace \_\_\_\_\_14. Maiden name Unknown15. Birthplace Int. Wilson Sanatorium16. Informant Int. Wilson SanatoriumAddress \_\_\_\_\_17. Burial Date thereof April 20. 46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Balto. National CemeteryLocation Fredrick Rd. Balto. Md.18. Funeral director Frank H. NewellAddress Pikeville, Maryland19. 4-19- 19. 46 E. E. Nichols

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 4 19. 46 at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 4 19. 46 to Apr 4 19. 46and that I last saw him alive on Apr 4 19. 46Immediate cause of death Acute Alcoholism

DURATION

10 daDue to \_\_\_\_\_Due to \_\_\_\_\_Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. \_\_\_\_\_Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of \_\_\_\_\_Where did injury occur? None  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) \_\_\_\_\_Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_23. SIGNATURE D. D. Caples, M.D.

M. D. or other

Address Reisterstown, Md. Date signed 4-6-46

STANDARD FORM NO. 64

RECEIVED  
APR 22 1946  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 922

## CERTIFICATE OF DEATH

03518

Reg. Dist. No. 37

## 1. PLACE OF DEATH:

County BaltimoreCity or town Cockeysville Ind  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 yrs

Hospital, institution, or street address where death occurred:

Masonic Home, Cockeysville Ind

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind CountyCity or town Balto  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2411 Barclay St  
(If rural, give LOCATION) ✓

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mrs Mary Elizabeth Krington

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Wesley H. Ernest

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 6 - 18688. AGE: Years 77 Months 5 Days 5 If less than one day  
hrs. min.9. Birthplace Millerstown Pa.  
(Town, county, and state)10. Usual occupation seamstress

11. Industry or business

12. Name Wesley H. Ernest13. Birthplace Millerstown Pa.14. Maiden name Melinda Long15. Birthplace Millerstown Pa16. Informant Anna M. SchroederAddress Masonic Home, Cockeysville Ind17. Burial Date thereof April 8 - 46  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory GreenmountLocation Baltimore Ind18. Funeral director Geo. L. Beyer Jr.Address 1512 Hollins St19. April 6 - 19 46 L. M. Schroeder  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 19 46 at 12:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1 19 46 to April 5 19 46and that I last saw him alive on April 4 19 46Immediate cause of death Cardiac Failure

## DURATION

1 dayDue to Coronary Thrombosis

Due to

Other conditions Coronary Heart FailureAnterior Sclerotic C.V.D.  
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert Baldwin M. D. or otherAddress Bennie Branch R. Ellettsport Date signed 4/5/46



RECEIVED  
APR 9 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

Reg. Dist. No. 03520 43

## 1. PLACE OF DEATH:

County

City or town

13 Fuller Ave overlea

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Johanna F.

6. (c) If alive, give age

45

7. Birth date of deceased (mo., day, yr.)

May 2, 1897

8. AGE:

Years

Months

Days

11 less than one day

48

11

18

hrs.

min.

9. Birthplace

Balto Co.

(Town, county, and state)

10. Usual occupation

Machinist

11. Industry or business

FATHER

12. Name

John Kraus

13. Birthplace

Germany

MOTHER

14. Maiden name

Elizabeth Bauer

15. Birthplace

Germany

16. Informant

Johanna F. Kraus

Address

13 Fuller Ave

17.

(Burial, cremation, or removal. Which?)

Date thereof

4 22 46

Cemetery or crematory

Holy Redeemer

Location

4300 Belair Rd

18. Funeral director

M. W. D. W. D. W.

Address

7160 Belair Rd

19.

(Date rec'd by registrar)

4/22 46 D. W. Hedrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 20 1946 at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

April 19 1946 to April 20 1946

and that I last saw him alive on

April 15 1946

Immediate cause of death

Coronary Thrombosis

DURATION

3 weeks

Due to

Due to

Other conditions

Fire occurred in cellar -  
resulting in explosion fire caused collapse  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

S. E. W. D. W.

M. D. or other

Address

W. D. W.

Date signed 4/22/46

# MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore *1946*

Reg. Dist. No. *31*

## CERTIFICATE OF DEATH

*03521*

### 1. PLACE OF DEATH:

(a) County Baltimore  
 (b) City or town Rockdale  
 (If outside city or town limits, write RURAL and give town)  
 (c) Street address, hospital, or institution:  
3405 Rolling Road  
 (d) Length of stay in hospital or inst. (yrs., mos., or days) \_\_\_\_\_  
 (e) Length of stay in this community (yrs., mos., or days) \_\_\_\_\_

### 2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Baltimore  
 (c) City or town Rockdale  
 (If outside city or town limits, write RURAL and give town)  
 (d) Street No. 3405 Rolling Road  
 (If rural give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

### 3 (a) FULL NAME

Amelia M. Lages

### 3 (b) If veteran, name war

### 3 (c) Social Security

No. \_\_\_\_\_

### 4. Sex

Female

### 5. Color or race

White

### 6 (a) Single, married, widowed, or

divorced. Widowed

### 6 (b) Name of husband or wife Charles T. L. Lages

6. (c) If alive, give age \_\_\_\_\_ years

### 7. Birth date of deceased (mo., day, yr.) July 31, 1855

### 8. AGE:

Years

Months

Days

If less than one day

90

8

10

hr.

min.

### 9. Birthplace Baltimore County, Md.

(Town, county, and state)

### 10. Usual occupation

None

### 11. Industry or business

MOTHER FATHER

### 12. Name

Mr. Snyder

### 13. Birthplace

Germany

### 14. Maiden Name

Catherine Groff

### 15. Birthplace

Germany

### 16 (a) Informant Mrs. Lorenzo Kirk

(b) Address 3405 Rolling Rd., Rockdale

### 17 (a) Burial

(Burial, cremation, or removal)

### (b) Date thereof Apr. 12, 1946

(month) (day) (year)

### (c) Cemetery or crematory Mt. Olive Cemetery

Location Rockdale, Md.

### 18 (a) Funeral director

Arthur J. Lawrence

### (b) Address

4510 Liberty Hgts Ave.

### 19 (a) April 11, 1946

(Date rec'd by registrar)

### (b) Henry A. Carings

Registrar

### MEDICAL CERTIFICATION

20. Date of death April 10 19 46, at 1.45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from JULY 19 43, to APRIL 10 19 46, and that I last saw him alive on APRIL 10 19 46.

### Immediate cause of death

URÆMIA

### Duration

2 wks.

Due to NEPHRITIS, CHRONIC, PARANEPHYRITIC

3 yrs.

Due to HYPERTENSION

### Other conditions

(Include pregnancy within 3 months of death)

### Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

### PHYSICIAN

Underline the cause to which death should be charged statistically.

### 22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(d) Did injury occur about home, on farm, industrial place, in public place? \_\_\_\_\_ While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

### 23. Signature

Dr. Hoffman, M.D.

M. D. or other

Address 8 E. Read St.

Date signed 4/10/46

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

19260

RECEIVED

JUN 7 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

03522

P

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

## 1. PLACE OF DEATH:

County Baltimore CountyCity or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrs.

Hospital, institution, or street address where death occurred:

5536 Hutton Ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore CountyCity or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5536 Hutton Ave

(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Irma M. Laurer

## 3. (b) Social Security Number

218-12-2972

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

George Laurer

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

July-21-1894

## 8. AGE:

Years 51 Months 8 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 9. Birthplace

Jersey City - N. J.  
(Town, county, and state)

## 10. Usual occupation

House Wife -

## 11. Industry or business

- At Home

## FATHER

12. Name Joseph H. Rudiger

## 13. Birthplace

Jersey City - N. J.

## MOTHER

14. Maiden name Alma Haus

## 15. Birthplace

N. J.16. Informant Mr. George LaurerAddress 5536 Hutton Ave17. BurialDate thereof April 10-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lorraine Park CemeteryLocation Woodlawn, Md.Funeral director Charles J. SchuybAddress 505 N. Monroe St.

## 18. Funeral director

Address 505 N. Monroe St.Date of death 4/9 1946

A. W. Hedrick

Registral

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April, 7th 1946 at 8:45 P.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dec 31 1944 to Apr 7 1946and that I last saw her alive on April 7 1946

Immediate cause of death

Metastatic Carcinoma of  
Mediastinum and Stomach

DURATION

16 mos.

Due to

Primary Carcinoma Right

Due to

Mammary Gland

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Carcinoma of RightMammary Gland Date of op. 1944

Autopsy results

no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

Joshua H. Harman M.D. M. D. or other \_\_\_\_\_Address 6419 W. Madison Mill Rd. Date signed Apr 9Baltimore - 7 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

## CERTIFICATE OF DEATH

03523

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltoCity or town Catonville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Opitz Convalescent Home

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltoCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 424 Edgewood St  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

William A. Leitz

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widowed6. (b) Name of husband or wife Elva M. Leitz7. Birth date of deceased (mo., day, yr.) Aug 10<sup>th</sup> 1856 8. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 89 Months 8 Days 10 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.8. Birthplace Balto, Maryland  
(Town, county, and state)10. Usual occupation Retired Electrician

11. Industry or business

12. Name Andrew Leitz13. Birthplace Unknown

14. Maiden name

15. Birthplace

16. Informant Raymond E. LeitzAddress 424 Edgewood St.17. Burial Date thereof 4/23/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory WesternLocation Balto, Md.18. Funeral director William Cook Inc.Address 1217 St. Paul St.19. 4-22- 19 46 Amsterdam  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4-20 19 46 at 1230 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 14 19 46 to Apr 20 19 46 and that I last saw him alive on Apr 20 19 46Immediate cause of death Cerebral Hemorrhage - 2 days DURATIONDue to Cerebral Arterio Sclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Amsterdam M. D. or otherAddress Catonville Date signed 4-20



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 164a

## CERTIFICATE OF DEATH

03524

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County Baltimore  
City or town Baltimore - 6 - 5809 Westwood Ave  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State Md County Balto  
City or town Balto - 6 -  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5809 Westwood Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Homer Stewart Lyttle

### 3. (b) Social Security Number

None

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Myrtle

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 22, 1889

8. AGE: Years 57 Months 2 Days 16 It less than one day hrs. .... min.

9. Birthplace Russell Co Va  
(Town, county, and state)

10. Usual occupation Teacher (school)

11. Industry or business

12. Name Dore Lyttle

13. Birthplace Va

14. Maiden name Betty Singus

15. Birthplace Va

16. Informant James Lyttle

Address 5809 Westwood Ave. Balt 6. Md

17. Removal Date thereof APRIL 9, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory HILGORE

Location COEBURN, VIRGINIA

18. Funeral director WILLIAM COOK, INC.

Address 1217 ST. PAUL ST.

19. 4-9 46 Registrar Wm. H. H. H.

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 19 46 at 7:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death Thrombulation by DURATION 3 hrs.  
clotting

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 4-8-46

Where did injury occur? Balt 6 - Balt Md  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Long Runway Injured at work?

Signature Wm. H. H. H.

Address Wm. H. H. H. Date signed 4/8/46

MARGIN RESERVED FOR BINDING

(I)

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Bacon

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

03525 38  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County Baltimore  
City or town Baltimore - 14 (Barney)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
2919 Joppa Road  
How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2919 Joppa Road  
(If rural, give LOCATION)  
2.(a) If veteran, name war

## 3. (a) FULL NAME

Charles Wesley Marsh

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Emma E. Marsh

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9th, 1880

8. AGE: Years 65 Months 10 Days 5 If less than one day  
hrs. min.

9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation retired

11. Industry or business

FATHER 12. Name John Marsh  
13. Birthplace England

MOTHER 14. Maiden name Margaret Knotts  
15. Birthplace Maryland

16. Informant Mr. Charles T. Marsh  
Address 2 900 Chenoweth Avenue

17. Burial Date thereof 4/8/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parkwood Cem.Location Baltimore18. Funeral director Leonard J. RuckAddress 5305 Harford Road 14

19. 4/16 19 46 G.M. Bacon  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 4th, 19 46, at 2:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
April 1 19 46 to April 4 19 46  
and that I last saw him alive on April 4 19 46

Immediate cause of death Hemiplegia, right DURATION 4 days

Due to Hypertension and  
Chronic myocarditis 2 yrs +

Due to

Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G.M. Bacon, M.D.  
M. D. or other

Address 2810 Taylor Ave. Date signed 4/16/46

RECEIVED  
APR 8 1916  
BUREAU OF  
S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 180

## CERTIFICATE OF DEATH

03526

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Balto.City or town Chesaco Pk  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

715 Chesaco ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltoCity or town Chesaco Park  
(If outside city or town limits, write RURAL and give nearest town)Street No. 715 Chesaco ave

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Alice Roberta Mathoney

## 3. (b) Social Security Number

4. Sex fm. 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

June 28 - 1938

8. AGE:

Years

Months

Days

If less than one day

7 10   hrs. min.9. Birthplace Edgemore md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Ora Mathoney

13. Birthplace

Va.14. Maiden name Lottie B. O. Daniel

15. Birthplace

N. C.16. Informant Ora L. MathoneyAddress 715 Chesaco ave.17. Burial Date thereof 4/13/46

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Oak LawnLocation Eastern Ave.18. Funeral director John H. ConnellyAddress 418 Eastern Ave. Essex 2119. 4/13/46 John H. Connelly

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 12 1946 at 11:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 12 1946 to  19and that I last saw  alive on  19

Immediate cause of death

Suffocation by smokeDue to 2<sup>nd</sup> + 3<sup>rd</sup> Burns overentire body.Due to 

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 4/12/46Where did injury occur Chesaco Park Balto. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) at HomeMeans of Injury fire in home Injured at work? No23. SIGNATURE J. M. Barone M.D.Address Deputy Medical ExaminerDate signed 4/13/46

35200

STATE OF NEW YORK

RECEIVED  
APR 17 1946  
BUREAU V & S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 180

## CERTIFICATE OF DEATH

03527

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltoCity or town Chesaco Pk  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

715 Chesaco Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltoCity or town Chesaco Park  
(If outside city or town limits, write RURAL and give nearest town)Street No. 715 Chesaco Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Louise Marie Matheney

## 3. (b) Social Security Number

4. Sex Fem 5. Color or race White 6. (a) Single, married, widowed, or divorced Single6. (b) Name of husband or wife -7. Birth date of deceased (mo., day, yr.) Aug 6 - 1940 B. (c) If alive, give age - years8. AGE: Years 5 Months - Days - If less than one day - hrs. - min.9. Birthplace Balto City  
(Town, county, and state)10. Usual occupation -11. Industry or business -12. Name Ora Matheney13. Birthplace Va.14. Maiden name Lottie B. O. Daniel15. Birthplace N. C.16. Informant Ora L MatheneyAddress 715 Chesaco Ave.17. Burial Date thereof 4/13/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oak LawnLocation Eastern Ave.18. Funeral director John O ConnollyAddress 418 Eastern Ave. Essex 2119. 4/13/46 19 46 John O Connolly  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1946 at 11:45 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 12 1946 to - 19 -and that I last saw h. - alive on - 19 -Immediate cause of death Asphyxiation by smoke DURATIONDue to 2683° Burning overDue to cutting of gasOther conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -Date of op. -Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 4/12/46Where did injury occur? Chesaco Park, Balto. MD.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) at homeMeans of injury Fire in home Injured at work? no23. SIGNATURE Monbaraine MD. M.D. or otherAddress Dundalk, MD Date signed 4/13/46



33250

UNITED STATES DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL

RECEIVED  
APR 17 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE  
HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 03528

## 1. PLACE OF DEATH:

(a) ~~Baltimore~~, Maryland  
(b) Street address 8326 Beysl Ave  
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

## 3 (a) FULL NAME

Oscar H Mc Dorman

3 (b) If veteran, name war

3 (c) Social Security Account  
No. 217-08-3004

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Nelson M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-10-95

8. AGE: Years Months Days If less than one day  
50 11 8 hr. min.

9. Birthplace Somerset Co. Md.  
(Town, county, and state)

10. Usual Occupation Dist. Sup. American Store

11. Industry or business Grocery

12. Name E. Wright Mc Dorman

13. Birthplace Md.

14. Maiden Name Mary J. Dorney

15. Birthplace Md.

16 (a) Informant Mrs. Nelson M. Dorman

(b) Address 8326 Beysl Ave

17 (a) Burial (b) Date thereof 4-22-96  
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore National  
Location Balb. Md.

18 (a) Funeral director Leonard J. Ruck

(b) Address 5365 Harford Rd.

19 (a) 4-20-46 (b) as shown on TN Registrar  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Parkville  
(If outside city or town limits, write RURAL and give town)

(d) Street No. 8326 Beysl Ave  
(If rural give location)

(e) Citizen of foreign country? (Yes or No)  
If yes, name country

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1946, at 1:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18/1946 to 4/18/1946, and that I last saw him alive on 4/18/1946.

Immediate cause of death

Duration

Coronary  
Due to thrombosis

1 hour

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

## PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. E. Grant M. D.  
Address 8100 Harford Rd. signed 4/19/46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

03529

## CERTIFICATE OF DEATH

Reg. Diat. No. 43

## 1. PLACE OF DEATH:

County Baltimore CountyCity or town Parkville (Baltimore 14)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore Co.City or town Parkville (Baltimore 14)  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3009 Taylor Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Frances E. Emira McIntire

## 3. (b) Social Security Number

none

## 4. Sex

FEMALE

## 5. Color or race

WHITE

## 6. (a) Single, married, widowed, or divorced

WIDOWED

## 6. (b) Name of husband or wife

SAM. JEFFERSON McINTIRE6. (c) If alive, give age dec. years

## 7. Birth date of deceased (mo., day, yr.)

July 12 - 1858

## 8. AGE:

Years

87

Months

9

Days

6

If less than one day

1 hrs.30 min.

## 9. Birthplace

Lower Oxford Twp. Chester Co. Penna.  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

## FATHER

## 12. Name

Franklin Johnson

## 13. Birthplace

Chester Co., Penna.

## MOTHER

## 14. Maiden name

Mary Ann McClurg

## 15. Birthplace

Chester Co., Penna.

## 16. Informant

Address

## 17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

Apr. 22 '46

Cemetery or crematory

Oxford

Location

Oxford, Chester Co Penna

## 18. Funeral director

Larsen Funeral Home

Address

7401 Belair Rd

## 19.

(Date rec'd by registrar)

Apr 1819. 46Wm G. L. Perkins

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 18, 19 46, at 1:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 5 19 46, to April 18 19 46and that I last saw him alive on April 17, 19 46

Immediate cause of death

arteriosclerotic cardio-vascular renal

Due to

obvious

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Harold A. Grott, M.D.

M. D. or other

Address 8100 Hampden Rd.Date signed 4/18/46

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
APR 27 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

0353032

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Mount Wilson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 0 yrs., 3 mos., 3 days  
 Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium  
 How long in hospital or institution? 0 yrs., 3 mos., 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3212 W. Garrison Avenue  
 (If rural, give LOCATION)  
 2.(d) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

John McTaggart

## 3. (b) Social Security Number

No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Marie C. McTaggart  
 6. (c) If alive, give age 52 years  
 7. Birth date of deceased (mo., day, yr.) March 13, 1896  
 8. AGE: Years 50 Months 1 Days 5 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace New York, New York  
 (Town, county, and state)  
 10. Usual occupation Race Track Patrol Judge  
 11. Industry or business \_\_\_\_\_  
 FATHER 12. Name Daniel McTaggart  
 13. Birthplace Ireland  
 MOTHER 14. Maiden name Marie McDonald  
 15. Birthplace Vineland, New Jersey

16. Informant Mrs. Marie V. Moeller  
 Address 3212 W. Garrison Ave., Balto. Md.  
 17. Burial Burial Date thereof April 20, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Druid Ridge Cemetery  
 Location Reisterstown Rd., Maryland  
 18. Funeral director Loring Byers  
 Address 5005 Park Heights Ave., Balto., Md.  
 19. April 18, 1946 Earl Webster  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 18, 1946, at 3:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15, 1946 to April 18, 1946  
 and that I last saw him alive on April 18, 1946

Immediate cause of death General Miliary Tuberculosis DURATION 5 Mos.

Due to Tubercle Bacilli

Due to \_\_\_\_\_

Other conditions Tuberculous Epididymitis 1 Mo.  
 (Include pregnancy within 8 months of death)

Major findings of operations No operation

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Stewart S. Shaffer M.D. M. D. or other \_\_\_\_\_Address Mount Wilson, Md. Date signed 4/18/46

Rec'd 4-19-46 Len E. Nichols

RECEIVED

APR 22 1946

BUREAU V.A.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 45-8

## CERTIFICATE OF DEATH

03531

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Mount Wilson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 yrs., 9 mos., 16 days  
 Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium  
 How long in hospital or institution? 15 yrs., 9 mos., 16 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Mount Wilson  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

George H. Meekins

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) August 4, 1882  
 8. AGE: Years 63 Months 7 Days 30 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation None  
 11. Industry or business \_\_\_\_\_  
 12. Name William P. Meekins  
 13. Birthplace Baltimore, Maryland  
 14. Maiden name Anna H. Hild  
 15. Birthplace Baltimore, Maryland

16. Informant George H. Meekins  
 Address Mount Wilson, Maryland  
 17. Burial Date thereof April 6, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St. Mary's Star of The Sea  
 Location Meekins' Point, Maryland  
 18. Funeral director George T. Evans  
 Address 118 W. Mt. Royal Ave., Balto., Md.  
 19. April 3, 1946 Earl T. Webster  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1946 at 1:20 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 18, 1930 to April 3, 1946  
 and that I last saw him alive on April 3, 1946  
 Immediate cause of death  
Coronary Occlusion  
Nephritis  
 Due to Arteriosclerosis  
Hypertension  
 Due to Cancer of pillar of tonsil  
 Other conditions Pulmonary Tuberculosis

## DURATION

1 Yr.

20 Yrs.

20 Yrs.

20 Yrs.

8 Mos.

24 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations No operation  
 Date of op. \_\_\_\_\_

Autopsy results No autopsy  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Stewart S. Shaffer m.d. M. D. or other  
 Address Mount Wilson, Md. Date signed 4/3/46

Rec'd 4-5-46 Dr. E. E. Nichols

RECEIVED  
APR 6 1946  
BUREAU 4 R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03532

Reg. Dist. No. 41

<b>1. PLACE OF DEATH</b> County <u>Baltimore</u> City or town <u>Bundall, Maryland</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Baltimore</u> County <u>Baltimore</u> City or town <u>Bundall, Maryland</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>26 Liberty Parkway</u> (If rural, give LOCATION) 2.(a) If veteran, name war			
<b>3. (a) FULL NAME</b> <u>Elizabeth Blanch Miller</u>				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> <u>Female</u>		<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Married</u>		<b>MEDICAL CERTIFICATION</b>	
<b>6. (b) Name of husband or wife</b> <u>Francis C. Miller</u>				<b>2D. DATE OF DEATH</b> <u>Apr 12</u> 19 <u>46</u> , at <u>12:30 P.M.</u>			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>Nov. - 6 - 1891</u>				<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>Mar 1</u> 19 <u>45</u> to <u>Apr 12</u> 19 <u>46</u> and that I last saw him alive on <u>Apr 12</u> 19 <u>46</u>			
<b>8. AGE:</b> Years <u>54</u> Months <u>5</u> Days <u>6</u> It less than one day hrs. min.		<b>6. (c) If alive, give age</b> <u>54</u> years		<b>Immediate cause of death</b> <u>Myocarditis</u>			
<b>9. Birthplace</b> <u>West Moreland Co. - Pa.</u> (Town, county, and state)				<b>Due to</b> <u>Rheumatic heart disease</u>			
<b>10. Usual occupation</b>				<b>Due to</b>			
<b>11. Industry or business</b> <u>At Home</u>				<b>Other conditions</b>			
<b>12. Name</b> <u>William Dunmire</u>				<b>(Include pregnancy within 3 months of death)</b>			
<b>13. Birthplace</b> <u>West Moreland Co. - Pa.</u>				<b>Major findings of operations</b>			
<b>14. Maiden name</b> <u>Laura Gardner</u>				<b>Date of op.</b>			
<b>15. Birthplace</b> <u>West Moreland Co. - Pa.</u>				<b>Autopsy results</b>			
<b>16. Informant</b> <u>Francis C. Miller</u>				<b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>			
<b>Address</b> <u>26 Liberty Parkway</u>				<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b>			
<b>17. Burial</b> (Burial, cremation, or removal. Which?) Date thereof <u>4/15/46</u> (month) (day) (year)				<b>Accident, suicide, or homicide</b>			
<b>Cemetery or crematory</b> <u>Meadowidge Cem.</u>				<b>Where did injury occur?</b> (City or town) (County) (State)			
<b>Location</b> <u>Washington Blvd.</u>				<b>Injured at home, farm, industry, public place (where?)</b>			
<b>18. Funeral director</b> <u>John C. Miller Inc.</u>				<b>Means of injury</b>			
<b>Address</b> <u>2435 E. Oliver Street</u>				<b>Injured at work?</b>			
<b>19. 4-15</b> (Date rec'd by registrar)				<b>23. SIGNATURE</b> <u>David H. Andrew M.D.</u> M. D. or other			
<b>19. 46</b> (Date rec'd by registrar)				<b>Address</b> <u>2435 E. Oliver Street</u>			
<b>19. 46</b> (Date rec'd by registrar)				<b>Date signed</b> <u>4/13/46</u>			

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

03533

## 1. PLACE OF DEATH

County Balto.

Village or City

Armstrong Nursing HomeRegistration Dist. No. 38

St.

Ward

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## 2. FULL NAME

JOHN A. MILLERD.C.

If U. S. Veteran, specify WAR

None

(a) Residence: No.

2210 Whittier Ave.

St.

Ward.

(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED,  
OR DIVORCED (write the word)Married

5a. If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofMinnie C. (Schloeman) Miller

6. DATE OF BIRTH (month, day, and year)

May 24, 1867

7. AGE

Years

Months

Days

If LESS than

1 day, ----- hrs.

or ----- min.

781012

OCCUPATION

8. Trade, profession, or particular  
kind of work done, as SPINNER,  
SAWYER, BOOKKEEPER, etc.Retired9. Industry or business in which  
work was done, as SILK MILL,  
SAW MILL, BANK, etc.10. Date deceased last worked at  
this occupation (month and  
year)11. Total time (years)  
spent in this  
occupation

12. BIRTHPLACE (city or town)

Baltimore, Md.

(State or country)

FATHER

13. NAME

Ambrose Miller

14. BIRTHPLACE (city or town)

Germany

(State or country)

MOTHER

15. MAIDEN NAME

Mary C. Durwart

16. BIRTHPLACE (city or town)

Germany

(State or country)

17. INFORMANT

Mr. Lewis H. Miller

(Address)

702 Chumleigh Rd.

18. BURIAL, CREMATION, OR REMOVAL

Place

Lorraine Cem.

Date

4/9/

19. 46

19. UNDERTAKER

WM. J. TICKNER & SONS

(Address)

Balto., Md.

20. FILED

April 8, 1946Arthur H. Miller

Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

April61946

(Month)

(Day)

(Year)

22. I HEREBY CERTIFY That I attended deceased from

July1935April1946I last saw him alive on 5 April, 1946; death is saidto have occurred on the date stated above, at 1145 A.M.The PRINCIPAL CAUSE OF DEATH and related causes of importance  
were as follows:Broncho Pneumonia

Date of onset

2 April 46

Other Contributory Causes of importance:

Chronic Myocarditis1935Arteriosclerosis1935

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy? No

23. If death was due to external causes (VIDUENCE) fill in also the following:

Accident, suicide, or homicide?

Date of injury

19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed)

Robert H. Miller

M. D.

(Address)

702 Chumleigh Rd. Towson 4 Md.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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## Example II

The principal cause of death and related causes of importance were as follows:

<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1242

## CERTIFICATE OF DEATH

03534

Reg. Dist. No. 44

## I. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 176 Days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp., Ft. Howard, Maryland  
 How long in hospital or institution? 176 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 806 Stiles Street  
 (If rural, give LOCATION)  
WW-I  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

JOSEPH MORISI

## 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced Single  
 B.(b) Name of husband or wife Single  
 7. Birth date of deceased (mo., day, yr.) 8-27-94 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 51 Months 7 Days 7 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Italy  
 (Town, county, and state)  
 10. Usual occupation Laborer  
 11. Industry or business \_\_\_\_\_  
 12. Name Paul Morisi  
 13. Birthplace Italy  
 14. Maiden name Rose Poggioli  
 15. Birthplace Italy

16. Informant Clinical Records, Vets. Adm. Hosp.  
 Address Ft. Howard, Maryland  
 17. Burial Date thereof April 8, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Baltimore National Ex.  
 Location Imperial Rd. Balt. Md  
 18. Funeral director Frank Della Noce  
 Address 52 W. Morley St  
 19. Apr 6 19 46 A. W. Volchick  
 (Date rec'd by registrar) Registrar A F d

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1946, at 6:10 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 10, 1945, to April 4, 1946  
 and that I last saw him alive on April 4, 1946

Immediate cause of death Cirrhosis of liver  
 Due to Chronic Alcoholism  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

## DURATION

8 Yrs.  
plus  
20 Yrs.  
plus

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert M. Cullison  
R.M. Cullison, M.D. Act. Chn. Director  
 Address Ft. Howard, Maryland Date signed 4-5-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 726

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

03535

## 1. PLACE OF DEATH:

County Baltimore County  
 City or town Woodlawn  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 yearsHospital, institution, or street address where death occurred:  
1932 Summit Avenue

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore CoCity or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1932 Summit Ave  
(If rural, give LOCATION)2.(a) If veteran, name war None

## 3. (a) FULL NAME

Ida Goldie Myers

## 3. (b) Social Security Number

4. Sex Female5. Color or race white6. (n) Single, married, widowed, or divorced married6. (b) Name of husband or wife Mr Ira B Myers7. Birth date of deceased (mo., day, yr.) Sept 28 18808. AGE: Years 65 Months 6 Days 12 If less than one day  
hrs. min.9. Birthplace Carroll Co Maryland  
(Town, county, and state)10. Usual occupation housekeeper11. Industry or business own home12. Name Frank Fowble13. Birthplace Baltimore Co Maryland14. Maiden name Martha Jackson15. Birthplace Carroll Co Maryland16. Informant Mr. Ernest MyersAddress 3420 Lyndale Ave17. Burial Date thereof 4/13/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Pleasant Grove Cem.Location Balto. Co., Md.18. Funeral director WM. J. TICKNER & SONSAddress Balto., Md.19. 4/11 46 A-W Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1946 at 3 A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1933 to April 10 1946  
and that I last saw him alive on April 18 1946Immediate cause of death Chronic Myocardial Degeneration

DURATION

Due to 11 yearsDue to Mitral Regurgitation (Heart) 1 yr  
Other conditions Arterial Hypertension 12 years  
(Include pregnancy within 3 months of death)Major findings of operations no operation

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joshua H. Armacost M.D.Address 6419 Windsor Mill Road signed April 10, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03535

## CERTIFICATE OF DEATH

Reg. Dist. No. 35

## 1. PLACE OF DEATH:

County BALTIMORECity or town WHITE HALL  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 32 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County BALTIMORECity or town WHITE HALL  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

CLIFFORD LE ROY NELSON

## 3. (b) Social Security Number

NONE

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife GEORGIA A NELSON6. (c) If alive, give age 60 years

7. Birth date of

deceased (mo., day, yr.) NOV. 8 1886

8. AGE:

Years

Months

Days

If less than one day

59514

hrs.

min.

9. Birthplace

HARFORD Co. MD

(Town, county, and state)

10. Usual occupation

MERCHANT

11. Industry or business

FATHER

12. Name

NICHOLAS NELSON

MOTHER

13. Birthplace

HARFORD Co. MD

14. Maiden name

LOVELLA LUCKEY

15. Birthplace

HARFORD Co. MD

16. Informant

MRS. GEORGIA A NELSON

Address

WHITE HALL MD17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof

APRIL 14 1946  
(month) (day) (year)

Cemetery or crematory

BETHEL

Location

WHITE HALL P.D. MD

18. Funeral director

Howard S. Markline

Address

White Hall, Md19. Apr. 23, 1946

(Date rec'd by registrar)

1946

Mrs. Howard S. Markline

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 22 1946 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1945 to April 22 1946  
and that I last saw him alive on April 21 1946

Immediate cause of death

apoplexy

Due to

hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Hubert Bortner Jr. D.

M. D. or other

Address

White HallDate signed Apr 23, 1946

CERTIFICATE OF DEATH

NAME OF DECEASED

STATE OF

DATE OF DEATH

RECEIVED  
APR 25 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

Reg. Dist. No. 03537

<b>1. PLACE OF DEATH:</b> County..... <u>Baltimore</u> City or town..... <u>Pikesville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>7 yrs</u> Hospital, institution, or street address where death occurred: <u>Augsburg Home</u> <u>Campfield Rd.</u> How long in hospital or institution?.....				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State..... <u>Md.</u> County..... <u>Baltimore</u> City or town..... <u>Pikesville</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>Campfield Rd.</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
<b>3. (a) FULL NAME</b> <u>Edith Nicholson</u>				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> <u>F.</u>		<b>5. Color or race</b> <u>W</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Widow</u>			
<b>6. (b) Name of husband or wife</b> <u>Edgar E.</u>				<b>6. (c) If alive, give age</b> ..... years			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>May 21 1854</u>				<b>8. AGE:</b> Years <u>81</u> Months <u>10</u> Days <u>17</u> If less than one day..... hrs. .... min.			
<b>9. Birthplace</b> <u>Woodlawn Md.</u> (Town, county, and state)				<b>10. Usual occupation</b> <u>None</u>			
<b>11. Industry or business</b> <b>FATHER</b> 12. Name..... <u>John P. Heacock</u> 13. Birthplace..... <u>Catonsville</u> <b>MOTHER</b> 14. Maiden name..... <u>Hannah Hantley</u> 15. Birthplace..... <u>Quaker Hill Md.</u>				<b>16. Informant</b> <u>Mr. Theo. Katenkamp</u> Address <u>Campfield Rd. Pikesville P.O.</u>			
<b>17. Burial</b> (Burial, cremation, or removal. Which?) Date thereof..... <u>April 11 46</u> (month) (day) (year) Cemetery or crematory..... <u>Mt. Olive Oak Crt. Rd.</u> <u>Randalstown</u> Location..... <u>L. Heemann and Son</u>				<b>18. Funeral director</b> Address <u>32 S. Broadway</u>			
<b>19. 4/8/</b> (Date rec'd by registrar)				<b>19. 46</b> <u>Tom E. Martin</u> Registrar			

MEDICAL CERTIFICATION	
<b>20. DATE OF DEATH</b> <u>April 8</u> 19 <u>46</u> , at <u>5:00</u> M	<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>1940</u> to <u>April 8, 1946</u> and that I last saw him alive on <u>April 6, 1946</u> Immediate cause of death..... <u>Coronary occlusion</u> DURATION..... ?
Due to..... Due to..... Other conditions..... (Include pregnancy within 3 months of death)	Major findings of operations..... Date of op..... Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.
<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?	<b>23. SIGNATURE</b> <u>Tom E. Martin</u> M. D. or other Address <u>Randalstown Md.</u> Date signed <u>4/8/46</u>

18227

RECEIVED

MAY 4 1946

BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03538

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 20 Days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp., Ft. Howard, Maryland  
 How long in hospital or institution? 20 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 701 North Carey Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WW-I

## 3. (a) FULL NAME

HARRY NICKENS

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married  
 8.(b) Name of husband or wife Mrs. Jennie Nickens  
 6.(c) If alive, give age 44 years  
 7. Birth date of deceased (mo., day, yr.) 12-24-1888

8. AGE: Years 57 Months 4 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace New Orleans, La.  
 (Town, county, and state)

10. Usual occupation Minister

11. Industry or business \_\_\_\_\_

12. Name Unknown  
 13. Birthplace "  
 14. Maiden name Unknown  
 15. Birthplace "

16. Informant Clinical Records, Vets. Adm. Hosp.  
 Address Ft. Howard, Maryland

17. Burial Date thereof 5-1-46  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Phila. Pa.

Location Phila. Pa.

18. Funeral director Charles R. Law  
 Address 802 Madison St., Balto., Md.

19. 4-29-46 Registrar  
 (to be filled by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 26, 19 46 at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6, 19 46 to April 26, 19 46

and that I last saw him alive on April 26, 19 46

Immediate cause of death Carcinomatosis, generalized.

DURATION

Unknown

Due to Primary site of carcinoma Unknown.

Due to Cancer

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert M. Cullison  
R.M. CULLISON, M.D. CLIN. DIR.  
 Address Ft. Howard, Md. Date signed 4-27-46



# MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 93d

Reg. Dist. No. 03539

## CERTIFICATE OF DEATH

### 1. PLACE OF DEATH:

(a) County Baltimore  
 (b) City or town Essex (Baltimore 21)  
 (If outside city or town limits, write RURAL and give town)  
 (c) Street address, hospital, or institution:  
325 N Marlyn Ave  
 (d) Length of stay in hospital or inst. (yrs., mos., or days)  
 (e) Length of stay in this community (yrs., mos., or days)

### 2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Baltimore  
 (c) City or town Essex  
 (If outside city or town limits, write RURAL and give town)  
 (d) Street No. 325 N Marlyn Ave  
 (If rural give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years

### 3 (a) FULL NAME

Henry Norris

### 3 (b) If veteran, name war

3 (c) Social Security No. None

### 4. Sex

Male

### 5. Color or race

White

### 6 (a) Single, married, widowed, or divorced.

Widower

### 6 (b) Name of husband or wife Emma Norris

6. (c) If alive, give age \_\_\_\_\_ years

### 7. Birth date of deceased (mo., day, yr.) 3/1/1860

### 8. AGE:

Years 86

Months 1

Days 26

If less than one day

\_\_\_\_ hr. \_\_\_\_ min.

### 9. Birthplace Baltimore County Md

(Town, county, and state)

### 10. Usual occupation Truck farmer

### 11. Industry or business

MOTHER / FATHER

### 12. Name J. Norris

### 13. Birthplace

Germany  
Unknown

### 14. Maiden Name

### 15. Birthplace

Germany

### 16 (a) Informant Mrs Stefan Rothermel

(b) Address 325 N Marlyn Ave

### 17 (a) Burial

(Burial, cremation, or removal)

### (b) Date thereof 4/30/46

(month) (day) (year)

### (c) Cemetery or crematory Oak Lawn

Location Eastern Ave

### 18 (a) Funeral director Funeral Home

(b) Address 7401 Belair Road

### 19 (a) 4-29-46

(Date rec'd by registrar)

### (b) John G. Connolly

Registrar

### MEDICAL CERTIFICATION

20. Date of death April 27 1946, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1946, to April 27 1946, and that I last saw him alive on April 27 1946.

Immediate cause of death Coronary thrombosis

Duration Ex sudden

Due to arteriosclerosis

cardio-vascular disease

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

### PHYSICIAN

Underline the cause to which death should be charged statistically.

### 22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(d) Did injury occur about home, on farm, industrial place, in public place? \_\_\_\_\_ While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature J. M. Baumgardner

M. D. or other

Address Baltimore

Date signed 4-27-46

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 2 1946  
BUREAU V.F.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 470

## CERTIFICATE OF DEATH

Reg. Dist. No.

03540

P

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 Days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp., Ft. Howard, Maryland  
 How long in hospital or institution? 5 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1903 West Lanvale Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war VW-I

## 3.(a) FULL NAME

PETER P. NOWAKOWSKI

## 3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Mrs. Grace Nowakowski 6.(c) If alive, give age 55 years  
 7. Birth date of deceased (mo., day, yr.) 6-5-91  
 8. AGE: Years 54 Months 10 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace Baltimore, Maryland  
 (Town, county, and state)  
 10. Usual occupation Unemployed  
 11. Industry or business \_\_\_\_\_  
 12. Name Steven Nowakowski  
 13. Birthplace Poland  
 14. Maiden name Mary Lorek  
 15. Birthplace Poland

16. Informant Clinical Records, Vets. Adm. Hosp.  
 Address Ft. Howard, Maryland  
 17. Burial April 17, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Baltimore National Cemetery  
 Location Baltimore, Maryland  
 18. Funeral director M. J. Sadowski & Sons  
 Address 1808 Eastern Avenue  
 19. 4/15 1946 A. W. Hedrick  
 (by registrar) (signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13/46 1946 at 6:50 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
April 8, 1946 to April 13, 1946  
 and that I last saw him alive on April 13, 1946  
 Immediate cause of death Bronchogenic carcinoma with metastasis to the ribs and bones of the pelvis.  
 DURATION Unknown  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury Robert M. Cullison Injured at work?  
 23. SIGNATURE ROBERT M. CULLISON, M.D. M. D. or other  
 Address Fort Howard, Maryland Date signed 4/13/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 222

## CERTIFICATE OF DEATH

03541

P

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County: BaltimoreCity or town: Port Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, MarylandHow long in hospital or institution? 12 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: \_\_\_\_\_City or town: Baltimore, Dundalk, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6529 Parnell  
(If rural, give LOCATION)2.(a) If veteran, name war WW-2

## 3.(a) FULL NAME

PAUL A. PILOTTE

## 3.(b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife: Widowed

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

12-11-02

## 8. AGE:

Years

Months

Days

If less than one day

43410

hrs.

min.

9. Birthplace: Illinois

(Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business

FATHER  
MOTHER12. Name: John Pilotte13. Birthplace: Illinois14. Maiden name: Mary Beese15. Birthplace: Illinois16. Informant: Clinical Records, Vets. Adm. Hosp.Address: Ft. Howard, Maryland

17. Burial

(Burial, cremation, or removal, Which?) Date thereof \_\_\_\_\_ (month) (day) (year)

Cemetery or crematory: Fort Howard CemeteryLocation: Fort Howard, Indiana18. Funeral director: A. Lee, OderAddress: 4644 York Road., Balto., Md.19. 4-22 19 46  
(City or town) (year)Curved male  
Rwath Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 21, 19 46, at 10: M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 9, 19 46 to 4-21- 19and that I last saw him alive on April 21, 19

Immediate cause of death

Acute Military Tuberculosis

DURATION

9 Wks.plus

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE: Robert M. Cullison  
R.M. CULLISON, MD., ACTING CHIEF: DIRT

Address \_\_\_\_\_ Date signed \_\_\_\_\_

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

03542

Reg. Dist. No.

## 1. PLACE OF DEATH:

County... Balto.  
 City or town... Pikesville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
 Hospital, institution, or street address where death occurred:

7000 Alden Rd.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Baltimore  
 City or town... Pikesville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... 7000 Alden Road  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

BARBARA PISTEL

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widow

## 6. (b) Name of husband or wife

William E. Pistel

6. (c) If alive, give age... years

## 7. Birth date of deceased (mo., day, yr.)

Oct. 24, 1874

## 8. AGE:

Years

71

Months

5

Days

7

If less than one day

hrs.

min.

## 9. Birthplace

Baltimore, Md.

(Town, county, and state)

## 10. Usual occupation

None

## 11. Industry or business

FATHER

## 12. Name

John Eckstein

## 13. Birthplace

Germany

MOTHER

## 14. Maiden name

Catherine Urban

## 15. Birthplace

Germany

## 16. Informant

Mrs. Edna M. Schaeffer

## Address

7000 Alden Road, Pikesville

## 17.

Burial

(Burial, cremation, or removal. Which?)

## Date thereof

4/4/46

(month) (day) (year)

## Cemetery or crematory

Loudon Park Cem.

## Location

Balto., Md.

## 18. Funeral director

WM. J. TICKNER & SONS

## Address

Balto., Md.

## 19.

4-3 Kb

(Date rec'd by registrar)

19

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

April 1, 1946 at 7:15 A.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 13, 1946 to April 1, 1946and that I last saw him alive on April 1, 1946

## Immediate cause of death

## DURATION

Heart failure1 hr

## Due to

Coronary Thrombosis> hrs.

## Due to

arteriosclerosisyears

## Other conditions

Gingivitis, Rheumatoid arthritis

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of... \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

## 23. SIGNATURE

Louis Tabernan, M.D.Address... 1413 Reisterstown Rd. Pikesville 8 Md.

M. D. or other

Date signed April 1/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1472

## CERTIFICATE OF DEATH

03543

★ Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Balto  
 City or town Danmels  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balto  
 City or town Danmels  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Jesse W Porter

## 3. (b) Social Security Number

213-09-6050

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Eleanor Porter7. Birth date of deceased (mo., day, yr.) 1878 8.(c) If alive, give age \_\_\_\_\_ years8. AGE: Years 68 Months ? Days ? If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

12. Name Unknown13. Birthplace "14. Maiden name "15. Birthplace "16. Informant Roy SmithAddress Bella Md.17. Burial Date thereof 4-25-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory BethanyLocation Taggerville Md.18. Funeral director F.C. Reg. in BaltimoreAddress Elmott City Md.19. 4-22 1946 Harrold Miller  
(Date rec'd by registrar) (year) (month) (day) (Deputy Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 22 1946 at 3:15 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 22 1946 to 19and that I last saw him dead on Apr 22 1946Immediate cause of death Suicide - Gun shot woundFractures of Skull

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of Apr 22 1946Where did injury occur? Danmels Balto Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Gun Shot Injured at work? No23. SIGNATURE D. D. Caples M. D. or otherAddress Reisterstown Md. Date signed 4-22-46



RECEIVED  
APR 25 1946  
BUREAU T. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

## CERTIFICATE OF DEATH

03544

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County BaltimoreCity or town Relay  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4-19-44

Hospital, institution, or street address where death occurred:

Relay SanitariumHow long in hospital or institution? 4-19-44

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa. County Montgomery Co.City or town Gwynedd Valley  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION) ✓

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Poultney, Eugene

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male

white

widowed

6. (b) Name of husband or wife Ella Patterson Poultney7. Birth date of deceased (mo., day, yr.) Jan. 25 1873 8. (c) If alive, give age \_\_\_\_\_ years Oct 23 18718. AGE: Years 71 Months 7 Days 10 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Baltimore, Md.  
(town, county, and state)10. Usual occupation Real Estate Business

11. Industry or business

FATHER 12. Name S. Eugene Poultney13. Birthplace Baltimore, Md.MOTHER 14. Maiden name Lela L. Minis15. Birthplace Georgia16. Informant Brother - E. Curzon PoultneyAddress Gwynedd Valley, Montgomery Co., Pa.17. (Burial, cremation, or removal. Which?) Burial Date thereof Apr 5 1946  
(month) (day) (year)Cemetery or crematory Green MountLocation Baltimore Md18. Funeral director Henry M. Jenkins & Sons Co.Address McCallish Orchard St19. 4-4 46 Acc. H. H. H. H.  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1946 at 10:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 15 1946 to April 2 1946and that I last saw him alive on April 2 1946Immediate cause of death Coronary thrombosis

## DURATION

8 daysDue to Myocardial infarction

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of \_\_\_\_\_Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

SIGNATURE Eugene P. Poultney M.D.Address July 21, 1946 Date signed 4/2/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-11

## CERTIFICATE OF DEATH

03545

Reg. Dist. No. 44

## I. PLACE OF DEATH:

County BaltimoreCity or town Raspeburg (Baltimore 6)  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Trump Mill Road Box 318

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town As in No 1  
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war No

## 3. (a) FULL NAME

Samuel D Prescoe

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Colored Married6. (b) Name of husband or wife Harriet Prescoe

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/21/18688. AGE: Years Months Days It less than one day  
77 6 26 hrs. min.9. Birthplace Baltimore County, Md  
(Town, county, and state)10. Usual occupation Farm Hand

## 11. Industry or business

12. Name Henry Prescoe13. Birthplace Baltimore County14. Maiden name Unknown

15. Birthplace

16. Informant Mrs Samuel D PrescoeAddress Trump Mill Road17. Burial Date thereof 4/18/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Putty Hill M E CemeteryLocation Putty Hill Md18. Funeral director Josephine Funeral HomeAddress 7401 Belair Road19. 4/17/46 19. 46 Joseph G. Connelly  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16/46 8:10 AM 1946 at 8:10 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1946 to April 16 1946 and that I last saw him alive on April 16 1946Immediate cause of death Cerebral apoplexy

## DURATION

StrokeDue to arterio-sclerotic cardiac  
vascular disease

Due to

Other conditions Epilepsy  
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

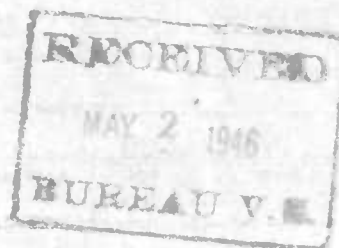
Means of injury Injured at work?

23. SIGNATURE Geo M. Baumgardner M. D. or otherAddress Baltimore Date signed 4-17-46

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Dr Baumgartner



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St. Baltimore

## CERTIFICATE OF DEATH

03546

Reg. Dist. No. 33

### 1. PLACE OF DEATH:

County Baltimore  
City or town Uppero  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 93 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County Balto  
City or town Uppero  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

John Wesley Price

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Emmeline Price

7. Birth date of deceased (mo., day, yr.) July 24 1848 8. AGE: Years 97 Months 9 Days 5 If less than one day

9. Birthplace Edenport City Md (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business Signature

12. Name John Price

13. Birthplace Uppero Md

14. Maiden name Unknown

15. Birthplace

16. Informant Mrs Rachel V. Gill

Address Uppero Md

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof May 1 - 46 (month) (day) (year)

Cemetery or crematory Pleasant Grove

Location Balto Co

18. Funeral director J P Elmer - Sons

Address Rustertown Md

19. 4-30 19 46 (Date rec'd by registrar)

Registrar Dora B. Elmer

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1946 12:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 44 to April 29 19 46

and that I last saw him alive on Apr 27 19 46

Immediate cause of death Langueurs of Lungs

Due to Emphysema

Due to Emphysema

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Edgar M. Bush M.D.

Address Baltimore Md

Date signed 4/29/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 2 1946

BUREAU V R



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-12)

## CERTIFICATE OF DEATH

03548

Reg. Dist. No. 37

### 1. PLACE OF DEATH:

County Baltimore  
City or town Texas  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution: Baltimore County Home  
Stay in hospital or inst. (yrs., or mos., or days) 5 yr. 8 mo. 9 da  
Stay in this community (yrs., or mos., or days) 5 yr. 8 mo. 9 da.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
City or town Essex Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. \_\_\_\_\_  
(If rural give LOCATION)  
2(a) IF VETERAN, NAME WAR \_\_\_\_\_

### 3. (a) FULL NAME

Nicholaus Riege

### 3. (b) Social Security Number

4. Sex M. 5. Color or race W 6. (a) Single, married, widowed, or divorced \_\_\_\_\_

6. (b) Name of husband or wife Agustia Klinoff.

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1876

8. AGE: Years 69 Months 7 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Germany  
(Town, county, and state)

10. Usual occupation Farm Laborer

### 11. Industry or business

12. Name Riege

13. Birthplace Germany

14. Maiden name Anna Strunk

15. Birthplace Germany

16. Informant Mrs. A. Nickel

Address 7011 Railway Ave Belts. 22 Md.

17. Burial Date thereof 5/1/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore County Home

Location Texas Md.

18. Funeral director John C. Connelly

Address 415 Eastern Ave. Essex Md.

19. 4/28 1946 W. J. Philcoat  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1946, at 3:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 10 1940, to Apr 28 1946, and that I last saw him alive on 4/26 1946.

Immediate cause of death Chronic Inflammation (Coma)

DURATION 3 mo.

Due to Arterio sclerosis

5 yrs.

Due to Senility

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

### PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Wilmer C. Evers M.D.

Address Cockeysville Md Date signed 4/28/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

45250

RECEIVED  
MAY 5 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (400)

03549

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County..... **Baltimore**  
 City or town..... **Catonsville**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **23 yrs., 4 mos., 1 day**  
 Hospital, institution, or street address where death occurred:  
**Spring Grove State Hospital**  
 How long in hospital or institution? **23 yrs., 4 mos., 1 day**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Maryland** County.....  
 City or town..... **At large**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3.(a) FULL NAME

**Stephen Ronek**

## 3.(b) Social Security Number

4. Sex <b>male</b>	5. Color or race <b>white</b>	6.(a) Single, married, widowed, or divorced <b>single</b>	
6.(b) Name of husband or wife..... -			
7. Birth date of deceased (mo., day, yr.) <b>1879</b>			
8. AGE: Years <b>67</b>	Months <b>?</b>	Days <b>?</b>	If less than one day .....hrs. ....min.
9. Birthplace..... <b>Germany</b> (Town, county, and state)			
10. Usual occupation..... <b>Baker</b>			
11. Industry or business..... <b>Baking</b>			
MOTHER	12. Name..... <b>?</b>		
	13. Birthplace..... <b>?</b>		
	14. Maiden name..... <b>?</b>		
MOTHER	15. Birthplace..... <b>?</b>		

16. Informant..... **Hospital records**  
 Address..... **Catonsville-28, Md.**

17. **Burial**  
 (Burial, cremation, or removal. Which?) Date thereof **May 3, 1946**  
 (month) (day) (year)  
 Cemetery or crematory..... **Spring Grove State Hospital**  
 Location..... **Catonsville 28, Maryland**  
 18. Funeral director..... **Spring Grove State Hospital**  
 Address..... **Catonsville 28, Maryland**

19. **5-4 - 1946**  
 (Date rec'd by registrar) **Harry J. Miller**  
 Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... **April 12** 19 **46**, at **6:05 a.m.**  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**December 11** 19 **22** to **April 12** 19 **46**  
 and that I last saw him alive on **April 12** 19 **46**  
 Immediate cause of death.....

	DURATION
<b>Carcinoma of the rectum</b>	<b>Indefinite</b>
Due to.....	
Due to.....	
Other conditions.....	

(Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....  
 Autopsy results..... **As above**  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of Injury..... Injured at work?  
**Isadore Tuerk**  
**Isadore Tuerk, M.D.**  
 23. SIGNATURE..... M. D. or other  
**Catonsville-28, Md.**  
 Address..... Date signed **4-12-46**

RECEIVED

MAY 5 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2500 MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore 94a  
CERTIFICATE OF DEATH

03550

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 5 days

Hospital, institution, or street address where death occurred:

Johnnysake Rd. near Ingleside Ave

How long in hospital or institution?.....

## 3. (a) FULL NAME

Emily Ruff

## 4. Sex

F

## 5. Color or race

W.

## 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Late Louis C. Ruff

7. Birth date of deceased (mo., day, yr.)

8. AGE:	Years	Months	Days	If less than one day
	28			hrs. min.

9. Birthplace

England

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Mrs. Virginia Cole

Address

Johnnysake &amp; Ingleside Road

17. Burial, cremation, or removal, Which?

Burial

Date thereof

Apr. 22/46.

(month) (day) (year)

Cemetery or crematory

New Cathedral

Location

4300 Old Frederick Rd.

18. Funeral director

Harry H. Nitzsche

Address

4101 Edmondson Ave

19. 4-20 1946 Harry H. Nitzsche

(Date rec'd by registrar)

Deputy Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Baltimore

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

Johnnysake Rd. near Ingleside

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

4/18/46. 19. 34. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1944 to April 18, 1946.

and that I last saw him alive on April 18, 1946.

Immediate cause of death

Coronary heart disease

DURATION

7 months

Due to

Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John A. Korchus

M. D. or other

Address

411 West 1st St.

Date signed

4/19/46

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF VETERANS AFFAIRS  
OFFICE OF THE ASSISTANT SECRETARY  
WASHINGTON, D. C. 20460  
CERTIFICATE OF DEATH

RECEIVED  
APR 22 1946  
BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

## CERTIFICATE OF DEATH

03551J4  
Reg. Diat. No.

### 1. PLACE OF DEATH

County Baltimore  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yr.

Hospital, institution, or street address where death occurred:

6800 Crossway

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Baltimore

City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6800 Crossway  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

EMERY PLATT# ROLAND

### 3. (b) Social Security Number

216-18-7543

4. Sex M. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mildred Kennedy

6.(c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) January 2, 1904

8. AGE: Years 42 Months 3 Days 9 If less than one day  
.....hrs. ....min.

9. Birthplace Augusta - Georgia  
(Town, county, and state)

10. Usual occupation Machinist BRM - 98

11. Industry or business Bethlehem Steel Corp.

12. Name Emery P. Roland

13. Birthplace Washington D.C.

14. Maiden name Eula Benson

15. Birthplace Augusta Ga.

16. Informant Mrs. Mildred Roland

Address 6800 Crossway, Dundalk

17. Date thereof 4/12/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Magnolia

Location Augusta Ga.

18. Funeral director John S. Connolly

Address 418 Eastern Ave. Essex 21

19. April 12 19 46 John S. Connolly  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 19 46 at 2:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
.....19....., fo.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....

Coronary Occlusion DURATION 2 hrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE MB Davis MD

Asst. Med. Examiner, Baltimore  
Address Baltimore Md Date signed 4/12/46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16660

RECEIVED  
APR 17 1946  
BUREAU OF

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

03552

1. PLACE OF DEATH:  
County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 42 years, 5 months, 2 days  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution? 42 years, 5 months, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County \_\_\_\_\_  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. unknown  
(If rural, give LOCATION) ✓  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Elizabeth Russel

### 3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife unknown  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years 83 Months ? Days ? If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Virginia  
(Town, county, and state)

10. Usual occupation unknown

11. Industry or business unknown

12. Name unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant Hospital Records

Address Catonsville 28, Md.

17. Burial Date thereof 4/11/46  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory mt. Olive Cem

Location Fandallstown Md.

18. Funeral director E. Ellis Lamoreau

Address 4510 Liberty Hgts Ave

19. 4-11 19 46 Harriet Miller Registrar  
(Registrar's signature) (year) (month) (day) (deputy)

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 19 46 at 9:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 6 19 03 to April 8 19 46

and that I last saw him er alive on April 8 19 46

Immediate cause of death Chronic Myocarditis

DURATION Indef.

Due to Generalized Arteriosclerosis Indef.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Isadore Tuerk

Address Catonsville 28, Md. M. D. or other \_\_\_\_\_ Date signed 4/9/46

MARGIN RESERVED FOR BINDING

VS A15 9-43-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

82030

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

ARTIST'S LETTER

RECEIVED

APR 15 1946

BUREAU V.R.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

## CERTIFICATE OF DEATH

03553

Reg. Dist. No. 30

### 1. PLACE OF DEATH:

County Baltimore

City or town Franklinstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 1

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Baltimore

City or town Franklinstown  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Inglewood Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Elizabeth Wilhelmina Aakers

### 3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

John W. Aakers

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 26 1862

8. AGE:

Years

83

Months

4

Days

20

It less than one day

hrs. min.

9. Birthplace

Queen Anne Co. Md.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER

12. Name

William T. Sears

13. Birthplace

Md.

14. Maiden name

Elizabeth Crier

15. Birthplace

Md.

16. Informant

Lloyd E. Aakers

Address

Inglewood Ave.

17.

(Burial, cremation, or removal. Which?)

Date thereof

4-18-46  
(month) (day) (year)

Cemetery or crematory

Lorraine Park

Location

Woodlawn Md.

18. Funeral director

J. Howard Strong

Address

3207 W. North Ave.

19.

(Date filed by registrar)

4/18 46 A.W. Hedrick  
Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 15th 1946 9:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 14, 1946 to April 15, 1946

and that I last saw her alive on April 15, 1946

Immediate cause of death

Cerebral hemorrhage

DURATION

Due to

Chronic Hypertension

Due to

+ chronic changes

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Howard W. Hedrick  
M.D. or other  
Cotonsville, Md. Date signed 4/16/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03554

Reg. Dist. No. 30

1. PLACE OF DEATH Baeto  
 County Catoara  
 City or town Catoara  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 11 months - 29 days  
 Hospital, institution, or street address where death occurred:  
Only Home  
 How long in hospital or institution? 11 months - 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Frederick  
 City or town Libertytown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME Mary Angela Sappington 3. (b) Social Security Number none

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) 4-7-1863 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 83 Months 0 Days 22 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Libertytown - Md.  
 (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business \_\_\_\_\_

12. Name Mrs. Augustine A. Sappington  
 13. Birthplace Libertytown - Md.

14. Maiden name Irene M. Mants  
 15. Birthplace Frederick Md.

16. Informant James Sappington  
 Address Libertytown - Md.

17. Burial Date thereof 5-2-46  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Peter's Cemetery  
 Location Libertytown - Md.

18. Funeral director C. E. Clive & Son  
 Address Frederick Md.

19. 4-30-46 19. 46 Larry J. Miller  
 (Date rec'd by registrar) (Date signed by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 19 46 at 9:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 19 45 to Apr 29 19 46  
 and that I last saw him alive on Apr 29 19 46

Immediate cause of death Cerebral thrombosis DURATION 10 days

Due to Cerebral Arterio Sclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James Sappington M. D. or other

Address Catoara Date signed 4-30



RECEIVED

MAY 2 1946

BUREAU V.I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

## CERTIFICATE OF DEATH

03555

Reg. Diat. No. 44

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 Day  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp. Ft. Howard, Maryland  
 How long in hospital or institution? 1 Day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester  
 City or town Clear Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ★ (If rural, give LOCATION)  
 2.(a) If veteran, name war WW-I

## 3. (a) FULL NAME

CHARLES E. SAYLOR

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Mrs. Miriam Saylor  
 6.(c) If alive, give age 56 years  
 7. Birth date of deceased (mo., day, yr.) 9-3-90  
 8. AGE: Years 55 Months 7 Days 20 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Pennsylvania  
 (Town, county, and state)  
 10. Usual occupation School Bus Driver  
 11. Industry or business  
 12. Name Abram Saylor  
 13. Birthplace Franklin Co., Pa.  
 14. Maiden name Alice L. Bowers  
 15. Birthplace Washington Co., Md.

16. Informant Clinical Records, Vets. Adm. Hosp.  
 Address Ft. Howard, Maryland

17. Burial Date thereof April 30, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Mt. Tabor Cemetery  
 Location Fairview, Maryland

18. Funeral director Snyder & Rowland  
 Address Clear Spring, Md.

19. April 30 19 46 W. H. H. H. H. Registrar  
W. H. H. H. H. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 23, 19 46, at 3:46 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22, 19 46, to April 23, 19 46, and that I last saw him alive on April 23, 19 46.

Immediate cause of death Pericarditis adhesive constrictiva DURATION Unknown

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Arteriosclerotic heart disease and Pulmonary emphysema  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results Substantiated above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert M. Cullison  
R. M. CULLISON, M.D. ACT. CLIN. DIR.  
 Address Ft. Howard, Md. Date signed 4-24-46

22220

11-11-46

ARTESIAN CREEK

CROSS COUNTRY



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH (482)

Registered No. 718

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

## 3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

## 2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 2<sup>nd</sup>, 1946, at 12:54 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1945 to April 2<sup>nd</sup>, 1946, and that I last saw her alive on Apr 2<sup>nd</sup>, 1946.

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1317

03557

P

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County..... Balto.  
 City or town..... Essex  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... Patapsco Rd.  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother) Balto.  
 State..... Md. County.....  
 City or town..... Essex  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Patapsco Rd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

MARGARET A. SHAKESPEARE

## 3. (b) Social Security Number

4. Sex Female	5. Color or race White	6. (a) Single, married, widowed, or divorced Widow
------------------	---------------------------	---

8. (b) Name of husband or wife..... Harry G. Shakespeare  
 7. Birth date of deceased (mo., day, yr.)..... 9-26-73  
 B. (c) If alive, give age..... years  
 8. AGE: Years..... 72 Months..... 6 Days..... 23 If less than one day..... hrs. .... min.

9. Birthplace..... Oxford, Md.  
 (Town, county, and state)  
 10. Usual occupation..... House  
 11. Industry or business.....  
 FATHER  
 12. Name..... John S. Haddaway  
 13. Birthplace..... Oxford, Md.  
 MOTHER  
 14. Maiden name..... Mary Fox  
 15. Birthplace..... Oxford, Md.  
 16. Informant..... Mr. Raymond H. Shakespeare  
 Address..... Patapsco Rd., Box 298, Essex 21

17. Burial..... Date thereof..... 4/23/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Loudon Park Cem.  
 Location..... Balto., Md.  
 18. Funeral director..... WM. J. TICKNER & SONS  
 Address..... Balto. Md.

19. 4/23 46 Quicker  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 19, 1946 at 3:10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
April 14 1946 to April 19 1946  
 and that I last saw her alive on April 19 1946

Immediate cause of death.....  
Chronic Hepatitis  
 Due to.....  
 Due to.....  
 Other conditions..... Uremia  
 (Include pregnancy within 3 months of death)  
 Major findings of operations..... no  
 Date of op.....  
 Autopsy results..... no

PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of Injury..... Injured at work?

23. SIGNATURE..... James F. White M.D.  
 M. D. or other  
 Address..... 768 E. ...  
 Date signed..... 4/20/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03558

Reg. Dist. No. 31

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 month

Hospital, institution, or street address where death occurred:

City Home for InvalidsHow long in hospital or institution? 1 month

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1431 Washington Blvd.  
(If rural, give LOCATION)2.(a) If veteran, name war None

## 3.(a) FULL NAME

George Shawker

## 3.(b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Mary Elizabeth Shawker6.(c) If alive, give age — years

7. Birth date of

deceased (mo., day, yr.)

September 25, 1857

8. AGE:

Years

Months

Days

If less than one day

8869

hrs.

min.

9. Birthplace

Howard County, Md.

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

Retired

FATHER

12. Name

Unknown

13. Birthplace

MOTHER

14. Maiden name

Unknown

15. Birthplace

16. Informant

Morris Calvin Shawker

Address

1253 Stevens Avenue, Arbutus17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

4-6-46

(month) (day) (year)

Cemetery or crematory

Landon Park

Location

Baltimore, Maryland

18. Funeral director

George L. Schwal

Address

2101 Frederick Avenue19. 4-8

(Date rec'd by registrar)

19 46Harold Miller  
Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 3, 1946 at 1:45 P.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-2 19 46, to 4-3 19 46and that I last saw him alive on 4-3 19 46

Immediate cause of death

Myocardial Failure

DURATION

3da

Due to

Pericardial Arterio SclerosisCardiovascular Disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Joseph L. Laukaitis, MD  
Address 679 Washington Blvd Date signed 4/3/46

M. D. or other



RECEIVED

APR 5 1946

BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of birth date & age of deceased and date of death is shown on  
**FILM No. 104 MAY 13 1946**  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
 2411 N. Charles St., Baltimore  
**CERTIFICATE OF DEATH**

035190  
 Reg. Dist. No. 50

<b>1. PLACE OF DEATH</b> County <u>Baltimore</u> City or town <u>Catonsville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>2 years - 10 mos</u> Hospital, institution, or street address where death occurred: <u>HARLEM LODGE</u> How long in hospital or institution? <u>2 years - 10 mos</u>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County _____ City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>18 W. Read</u> (If rural, give LOCATION) 2.(a) If veteran, name war _____	
<b>3. (a) FULL NAME</b> <u>SAMUEL S. SMALL</u>		<b>3. (b) Social Security Number</b> <u>SMALL</u>	

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
B. (b) Name of husband or wife <u>MARY-E. SMALL</u>		
7. Birth date of deceased (mo., day, yr.) <u>SEPT. 9 - 1861 - 1863</u>		

8. AGE:	Years	Months	Days	If less than one day
82	84	7	14	hrs. min.

9. Birthplace	<u>Pennsylvania</u> (Town, county, and state)
---------------	--

10. Usual occupation	<u>Mechanical Engineer</u>
----------------------	----------------------------

11. Industry or business	<u>Rail Road Business</u>
--------------------------	---------------------------

12. Name	<u>George Small</u>
----------	---------------------

13. Birthplace	<u>Pennsylvania</u>
----------------	---------------------

14. Maiden name	_____
-----------------	-------

15. Birthplace	<u>York, Pa.</u>
----------------	------------------

16. Informant	<u>Dr. Mary E. Small</u>
---------------	--------------------------

Address	<u>18 - W. Read Street</u>
---------	----------------------------

17. Burial	Date thereof <u>Apr 26 - 46</u>
------------	---------------------------------

(Burial, cremation, or removal. Which?)	(month) (day) (year)
---	----------------------

Cemetery or crematorium	<u>Leaside Park</u>
-------------------------	---------------------

Location	<u>Woodlawn, Md.</u>
----------	----------------------

18. Funeral director	<u>F. B. Shippert &amp; Son</u>
----------------------	---------------------------------

Address	<u>300 Entwistle Place</u>
---------	----------------------------

19. Date rec'd by registrar	<u>4/26/46</u>
-----------------------------	----------------

Registrar	<u>_____</u>
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**MEDICAL CERTIFICATION**

20. DATE OF DEATH	<u>April 23 - 24, 1946</u> at <u>12:03</u> P.
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21. I CERTIFY that death occurred on the date above stated; that I attended deceased from	<u>August 1, 1944</u> to <u>April 23, 1946</u>
---	--

and that I last saw him alive on	<u>April 23, 1946</u>
----------------------------------	-----------------------

Immediate cause of death	<u>Cardiac Decompensation and jaundice</u>
--------------------------	--

Due to	<u>Generalized Arteriosclerosis</u>
--------	-------------------------------------

Due to	<u>Senile Degenerative Changes</u>
--------	------------------------------------

Other conditions	<u>Senile Psychosis</u>
------------------	-------------------------

(Include pregnancy within 8 months of death)	<u>3 years</u>
--	----------------

Major findings of operations	_____
------------------------------	-------

Antopsy results	_____
-----------------	-------

PHYSICIAN: Please underline the cause to which death should be charged statistically.	_____
---	-------

22. VIOLENCE: If death was due to external causes, fill in the following:	_____
---	-------

Accident, suicide, or homicide	Date of _____
--------------------------------	---------------

Where did injury occur?	(City or town) (County) (State)
-------------------------	---------------------------------

Injured at home, farm, industry, public place (where?)	_____
--	-------

Means of injury	Injured at work?
-----------------	------------------

23. SIGNATURE	<u>Adrian J. McCalland</u>
---------------	----------------------------

M. D. or other	<u>_____</u>
----------------	--------------

Address	<u>Hartem Lodge, Catonsville, Md.</u>
---------	---------------------------------------

Date signed	<u>Apr 23, 1946</u>
-------------	---------------------

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Certif of Birth Balto City  
#99098

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03560  
Reg. Dist. No. 142

Micis. 4/01 - 4/14/46

### 1. PLACE OF DEATH:

County Balto  
City or town Halbthorpe  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

5729 First ave

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Balto

City or town Halbthorpe  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5729 First ave  
(If rural, give LOCATION)

2.(a) If veteran, name war.

### 3. (a) FULL NAME

Earl Edwin Somers

### 3. (b) Social Security Number

215-10-2796

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mary Alice Somers

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1888 1887 6. (c) If alive, give age 53 years

8. AGE: Years 58 Months 3 Days 29 It less than one day hrs. min.

9. Birthplace Balto MD  
(Town, county, and state)

10. Usual occupation Mech. Salesman

11. Industry or business retired

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mary Alice Somers

Address 5729 First ave

17. Burial Date thereof April 6, 46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Frederick Park

Location Balto MD

18. Funeral director George L. Schuch

Address 2101 Frederick ave

19. April 4, 46 19 46  
(Date rec'd by registrar)

Registrar He Kieffer

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 19 46 at 3:20 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. alive on 19. to 19.

Immediate cause of death Coronary occlusion

Due to Cardiovascular disease

Due to sudden death

Other conditions Injury

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. Kieffer Earl Somers

Address 1010 Frederick ave Date signed 4-4-46

RECEIVED  
APR 10 1946  
BUREAU V E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 30

## 1. PLACE OF DEATH: Co

(a) Baltimore City, Maryland

(b) Street address 5501 Edmondson Ave

(c) Hospital or institution:

Good Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Baltimore  
(If outside city or town limits, write RURAL and give town)(d) Street No. 720 Linnard St  
(If rural give location)(e) Citizen of foreign country? (Yes or No)  
If yes, name country

## 3 (a) FULL NAME

Linden P. Stafford

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. none

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Linda Stafford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

11/31/1861

8. AGE:

Years

Months

Days

If less than one day

85

2

31

hr.

min.

9. Birthplace

Preston, Md.

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

FATHER

12. Name

John P. Stafford

MOTHER

13. Birthplace

Rel. Coates

14. Maiden Name

Rel. Coates

15. Birthplace

Rel.

16 (a) Informant

Mr James T. Stafford

(b) Address

730 Linnard St

17 (a)

Burial

(b) Date thereof

4/25/46

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Washington

Location

Lundock, Md.

18 (a) Funeral director

Wm. Dickerson

(b) Address

North Ave. Balto, Md.

19 (a)

4/25/46

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4-22 1946, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946, to 1946, and that I last saw him alive on 4-21 1946.

Immediate cause of death

acute myocardial infarction

Duration

Due to

arterio sclerosis

Due to

and severe anemia

Other Conditions

Cancer of gastro-intestinal tract;

in

primary site not determined Surg. R.

Date of operation

pos. malignancy

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

Means of injury

23. Signature

Address 3921 Edmondson Date signed 4-22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

03562

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex.....

5. Color or race.....

6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

32

hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER

12. Name.....

13. Birthplace.....

MOTHER

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17.

(Burial, cremation, or removal, Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19.

(Date rec'd by registrar)

19.

4/10/46

V E E Michaels  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

4/10/46

19. 46

at 1045 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mr.

19. 45

to Apr 10

19. 46

and that I last saw him alive on

Apr 10

19. 46

Immediate cause of death.....

acute pulmonary edema

DURATION

8 hrs.

Due to.....

Hypertension, cardiac

vascular disease

a year

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

Robert H. Williams

M. D. or other

Address.....

Pikesville, Md.

Date signed.....

4/10/46



MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
APR 13 1945  
BUREAU V.R.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 836

## CERTIFICATE OF DEATH

03563

Reg. Dist. No. 4X

1. PLACE OF DEATH:  
County Baltimore  
City or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 11 Days  
Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp., Ft. Howard, Maryland  
How long in hospital or institution? 11 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County \_\_\_\_\_  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1933 Druid Hill Avenue  
(If rural, give LOCATION)  
2(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

JAMES H. THOMPSON

### 3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Divorced  
6. (b) Name of husband or wife Fannie  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) July 7, 1901  
8. AGE: Years 44 Months 7 Days 29 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(Town, county, and state)  
10. Usual occupation Laundry Worker  
11. Industry or business \_\_\_\_\_  
FATHER 12. Name Unknown  
13. Birthplace Unknown  
MOTHER 14. Maiden name Fannie ?  
15. Birthplace Unknown

16. Informant Clinical Records, Vets. Adm. Hosp.  
Address Ft. Howard, Md.  
17. Burial Date thereof April 9, 1946  
(Burial, cremation, or removal, which?) (month) (day) (year)  
Cemetery or crematory Baltimore National Cem.  
Location Baltimore Co. Md.  
18. Funeral director Mrs. George H. Holland  
Address 1631 Druid Hill Ave.  
19. 4-9-46 Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1946 at 3:35 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25, 1946 to April 5, 1946  
and that I last saw him alive on April 5, 1946

Immediate cause of death Thrombosis, cerebral DURATION 3 Wks.  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Hemiplegia, right 3 Wks.  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert M. Cullison  
R.M. CULLISON, M.D. ACT. REGISTRAR.  
Address Ft. Howard, Md. Date signed 4-5-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Order Grant  
L. G.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (204)

## CERTIFICATE OF DEATH

03564

Reg. Dist. No. 80

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 12 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel  
 City or town Gambrells Post Office  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. -  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Joseph E. Thompson, Jr.

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single  
 6.(b) Name of husband or wife - 6.(c) If alive, give age - years  
 7. Birth date of deceased (mo., day, yr.) November 14, 1926  
 8. AGE: Years 19 Months 5 Days 4 If less than one day - hrs. - min.  
 9. Birthplace Washington, D. C.  
 (Town, county, and state)  
 10. Usual occupation none  
 11. Industry or business none  
 12. Name Joseph Thompson  
 13. Birthplace Maryland  
 14. Maiden name Hilda L. Thompson  
 15. Birthplace Maryland

16. Informant Hospital records  
 Address Catonsville-28, Md.  
 17. Burial Date thereof 4/20/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Fort Lincoln Cemetery  
 Location Prince George's County  
 18. Funeral director W. W. Chambers Co.  
 Address Rivendale Maryland  
 19. 4-19 19 46 Harry J. Muller  
 (by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 19 46 at 12:40 a.m.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
April 6 19 46 to April 18 19 46  
 and that I last saw him alive on April 18 19 46  
 Immediate cause of death Encephalitis  
 DURATION approx. 5 years  
 Due to -  
 Due to -  
 Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -  
 Autopsy results as above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide - Date of -  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) -  
 Means of injury - Injured at work? -  
 23. SIGNATURE Isadore Tuerk, M.D. M. D. or other -  
 Address Catonsville-28, Md. Date signed 4-18-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

03880

RECEIVED

APR 22 1945

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4870

## CERTIFICATE OF DEATH

03565

Reg. Dist. No. 4-4

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 119 Sellers Point Rd.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Alice V. Tyler

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

Col6. (a) Married, widowed, or divorcedwidow

6. (b) Name of husband or wife

William H. Tyler

7. Birth date of

8. (c) If alive, give age

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Baltimore  
(Town, county, and state)

10. Usual occupation

Home

11. Industry or business

domestic

12. Name

Hannibal Keith

13. Birthplace

deceased

14. Maiden name

Sarah Keith

15. Birthplace

va.

16. Informant

Address

17. Motor

(Burial, cremation, or removal. Which?)

Date thereof April 16, 1946  
(month) (day) (year)

Cemetery or crematory

Hollywood

Location

Virginia

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 13<sup>th</sup>19 46, at 2:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1946 to April 13<sup>th</sup> 1946  
 and that I last saw him alive on April 12<sup>th</sup> 1946

Immediate cause of death

Carcinoma of uterus

DURATION

unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

J. H. Thomas M.D.  
Baltimore

M. I. or other

Date signed 4/13/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17009

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 months, 27 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 2 months, 27 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County .....  
 City or town Baltimore-13  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3114 Lawnview Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Leonard Uhler (Leonard Spurrier Uhler)

## 3. (b) Social Security Number

705-09-3797

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Margaret V. Sharp  
 6. (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) May 11, 1884  
 8. AGE: Years 61 Months 10 Days 25 If less than one day ..... hrs. .... min.

9. Birthplace Pikesville, Maryland  
 (Town, county, and state)

10. Usual occupation Railroad conductor

11. Industry or business Railroad

12. Name Nicholas Uhler

13. Birthplace Carroll County, Maryland

14. Maiden name Anne Spurrier

15. Birthplace Unionbridge, Maryland

16. Informant Hospital records

Address Catonsville-28, Maryland

17. Burial Date thereof 4/9/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory DRUID RIDGE CEMETERY

Location BALTIMORE, MARYLAND

HENRY SANDER & SONS, INC.

16. Funeral director NORTH AVE. & BROADWAY

Address 4-8 46

19. 4-8 46 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 19 46, at 7:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19....., to ..... 19.....

and that I last saw him ..... alive on ..... 19.....

Immediate cause of death ..... DURATION

Crushed left chest  
rib fractured.  
punctured lung on left side

Chest contains fluid  
General injury to left chest

Other conditions .....  
 (Include pregnancy within 6 months of death)

Major findings of operations ..... Date of op. ....

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of April 2, 46

Where did injury occur? Catonsville, Balto. Md.  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Spring Grove State Hos.

Means of injury run over by auto truck Injured at work? no

23. SIGNATURE Ger. Kieffer M. D. or other

Address 1010 Leeds an Date signed April 5, 46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

## CERTIFICATE OF DEATH

03567

Reg. Dist. No. 30

1. PLACE OF DEATH:  
County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 13 months  
Hospital, institution, or street address where death occurred:  
Spitz Home for Invalids  
How long in hospital or institution? 13 months

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2608 Lehman Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war None

3. (a) FULL NAME Mary Ellen Wade

3. (b) Social Security Number None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) March 16, 1860

8. AGE: Years 86 Months - Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Arbutus Balto. County, Md.  
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

12. Name George H. Wade

13. Birthplace Maryland

14. Maiden name Marion Stewart

15. Birthplace Maryland

16. Informant James H. Wade

Address 2608 Lehman Street

17. Burial Date thereof 4-6-46  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Landon Park

Location Baltimore, Maryland

18. Funeral director George L. Schwalb

Address 2101 Fredrick Avenue

19. 4-6- 19 46 Harrell Miller  
(Date rec'd by registrar) Deputy Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1946 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2, 1946 to Apr 3, 1946 and that I last saw him alive on Apr 3, 1946

Immediate cause of death Cerebral Hemorrhage DURATION 3 days

Due to Cerebral Arteriosclerosis

Due to Sclerosis

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James H. Wade M. D. or other \_\_\_\_\_

Address Catonsville Date signed 4/4

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
APR 8 1946  
BUREAU V A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 733

## CERTIFICATE OF DEATH

Reg. Dist. No. 03568 32

## 1. PLACE OF DEATH:

County Balto.City or town Pikesville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
Campfield Rd.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Pikesville  
(If outside city or town limits, write RURAL and give nearest town)Street No. Campfield Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war none

## 3. (a) FULL NAME

CHARLES WALTHER

## 3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower6.(b) Name of husband or wife Anna M. Walther

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) March 25, 18588. AGE: Years 88 Months 0 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Germany  
(Town, county, and state)10. Usual occupation Retired Machinist11. Industry or business Sun Papers12. Name Unknown

13. Birthplace

14. Maiden name Unknown

15. Birthplace

16. Informant Mr. Edwin H. SchneiderAddress 4103 Forest Park Ave.17. Burial Date thereof 4/11/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Loudon Park Cem.Location Balto., Md.18. Funeral director WM. J. TICKNER & SONSAddress Balto., Md.19. 4-9- 19 46 Dr. E.E. Nichols  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 19 46, at 1:20 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7<sup>th</sup> 19 46 to April 8<sup>th</sup> 19 46and that I last saw him alive on April 7<sup>th</sup> 19 46Immediate cause of death Chronic Myocarditis DURATIONarterio. sclerosis

Due to

Due to

Other conditions Seizure 3 daysterminal pneumonia

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E.E. Nichols M. D. or otherAddress Pikesville - 8, Md. Date signed 4/9/46

RECEIVED  
APR 10 1946  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93rd

## CERTIFICATE OF DEATH

03569

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 5 yrs. 4 mos. 27 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution?..... 5 yrs. 4 mos. 27 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Washington, D.C. County.....  
 City or town..... Anacostia Station  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name War.....

## 3. (a) FULL NAME

Marian Warder

## 3. (b) Social Security Number

4. Sex..... Female  
 5. Color or race..... White  
 6. (a) Single, married, widowed, or divorced..... Single  
 6. (b) Name of husband or wife.....  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... October 22, 1872  
 8. AGE: Years..... 73 Months..... 6 Days..... 6  
 If less than one day..... hrs. .... min.

9. Birthplace..... Washington, D.C.  
 (Town, county, and state)  
 10. Usual occupation..... Housework  
 11. Industry or business..... None  
 FATHER  
 12. Name..... John T. Warder  
 13. Birthplace..... Unknown  
 MOTHER  
 14. Maiden name..... Emma A. Henderson  
 15. Birthplace..... Unknown

16. Informant..... Hospital Records  
 Address..... Spring Grove State Hospital  
 17. Burial..... Burial Date thereof..... 4-30-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Good Hope Bury.  
 Location..... Newberg Chas. Co. Md.  
 18. Funeral director..... J. H. Chambers Co.  
 Address..... 517-11th St. S.E.  
 19. 4-28-46 19. 46 Harry J. Miller  
 (Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 28 19. 46, at..... 1:25 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Dec. 1 19. 40, to April 28 19. 46  
 and that I last saw her alive on April 28 19. 46  
 Immediate cause of death.....  
Chronic Myocarditis  
 Due to.....  
Hypertensive Cardiac  
vascular Disease  
 Due to.....  
 Other conditions.....

## DURATION

Indefinite  
Indefinite

(Include pregnancy within 3 months of death)  
 Major findings of operations..... None  
 Autopsy results..... None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of Injury..... Injured at work?

23. SIGNATURE..... Isadore Funk, M.D.  
 M. D. or other  
 Address..... Spring Grove State Hosp. Date signed..... 4-28-46



00660

UNITED STATES DEPARTMENT OF JUSTICE

RECORDS TO STATE DEPT.

RECEIVED  
MAY 1 1946  
BUREAU

ARTISTIAN CENTER

NO CONTENT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12-2)

## CERTIFICATE OF DEATH

03570

Reg. Dist. No. 30

1. PLACE OF DEATH:  
County..... Balto.  
City or town..... Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
115 Newburg Ave.  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Md. County.....  
City or town..... Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 115 Newburg Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

## 3. (a) FULL NAME

GEORGIANNA WATSON

## 3. (b) Social Security Number

--

4. Sex..... Female  
5. Color or race..... White  
6.(a) Single, married, widowed, or divorced..... Married  
6.(b) Name of husband or wife..... Frank W. Watson  
7. Birth date of deceased (mo., day, yr.)..... Feb. 19, 1874  
8. AGE: Years..... 72 Months..... 2 Days..... 5 If less than one day..... hrs. .... min.

9. Birthplace..... Baltimore  
(Town, county, and state)  
10. Usual occupation..... Housewife  
11. Industry or business.....

FATHER  
12. Name..... Thomas G. DeFord  
13. Birthplace..... Balto.  
MOTHER  
14. Maiden name..... Georgianna Brady  
15. Birthplace..... Balto.

16. Informant..... Mr. Albert DeFord  
Address..... 4429 Clifton Rd. Balto.

17. Burial Date thereof..... 4/27/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory..... Loudon Park Cem.  
Location..... Balto., Md.

18. Funeral director..... WM. J. TICKNER & SONS  
Address..... Balto., Md.

19. 4/26 1946 A. W. J. DeWitt  
(Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 24, 1946 at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 1946, to April 24, 1946, and that I last saw her alive on April 24, 1946.

Immediate cause of death..... Cerebral Hemorrhage  
DURATION..... 3 wks.

Due to..... Chronic Cardiac-Vascular-Renal Disease  
DURATION..... 1 yr. (?)

Due to.....  
Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of .....  
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....  
Means of injury..... Injured at work?.....

23. SIGNATURE..... Wilson K. Gallagher M.D.  
M. D. or other.....  
Address..... Catonsville-28, Md. Date signed 4/25/46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03571

Reg. Dist. No. 40

## 1. PLACE OF DEATH:

County BaltimoreCity or town Notch Cliff near Towson  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Notch Cliff near Towson  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Sister Mary Clotilda Way

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 18908. AGE: Years Months Days If less than one day  
55 5 8 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Saginaw Mich.  
(Town, county, and state)10. Usual occupation Teacher

11. Industry or business \_\_\_\_\_

FATHER 12. Name Ignatius Way13. Birthplace St. Agatha, CanadaMOTHER 14. Maiden name Francis Dittus15. Birthplace St. Agatha, Canada16. Informant Sister Mary ClotildaAddress Notch Cliff, Md.17. Burial Date thereof Apr 4/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Green LawnLocation Notch Cliff18. Funeral director Geo M. Young & SonAddress 811 N. 4th St19. 4/2/46 19. Wm. J. ...  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 19. 46 at 6:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 22 19. 41 to April 1 19. 46and that I last saw him alive on March 22 19. 46

Immediate cause of death \_\_\_\_\_

Apoplexy DURATION Sudden

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Arterio sclerosis and Hypertension

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

22. SIGNATURE John Green Jr. M. D. or otherAddress Towson Date signed Apr 2/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17250

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

RECEIVED  
MAY 4 1946  
BUREAU OF INVESTIGATION

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

## CERTIFICATE OF DEATH

03572

Reg. Dist. No. 32

### 1. PLACE OF DEATH:

County... Baltimore  
City or town... Roslyn  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 Yr.  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?...

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State... Md. County... Baltimore  
City or town... Roslyn  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Old Court Rd. near Mill Road  
(If rural, give LOCATION)  
2.(a) If veteran, name war...

### 3.(a) FULL NAME

George W. Wilhelm

### 3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife... Mary E. Wilhelm

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1872 6.(c) If alive, give age... years

8. AGE: Years 74 Months 2 Days 4 If less than one day... hrs. min.

9. Birthplace... New Freedom, Pa.  
(Town, county, and state)

10. Usual occupation... Machinist

### 11. Industry or business

12. Name... Jacob Wilhelm  
13. Birthplace... Pa.

14. Maiden name... Margaret Boone  
15. Birthplace... Pa.

16. Informant Mrs. Mary E. Wilhelm  
Address Old Court Rd., Roslyn

17. Burial Date thereof... Apr. 24, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Mt. Olive  
Location... Roslyn, Md.

18. Funeral director... J. Howard Strong  
Address 3207 W. North Ave.

19. 4-22- 19 46 E. E. Nichols  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH... April 21, 1946 at P. 3.20

21. CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 19 46 to Apr 21 19 46  
and that I last saw him alive on April 21 19 46

Immediate cause of death... Sarcoma of left side of face & neck DURATION 1 1/2 yrs

Due to... General Atherosclerosis

Other conditions...  
(Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results...  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) A

Means of injury E. E. Nichols M.D. Injured at work?

23. SIGNATURE... E. E. Nichols M.D. M. D. or other  
Address... Pikesville - 8 Md. Date signed... 4-22-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

57854

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

RECEIVED

APR 23 1946

BUREAU OF INVESTIGATION



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 184

03573

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... BaltimoreCity or town..... Bare Hills, Baltimore Co.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? None  
Hospital, institution, or street address where death occurred:  
Woods at Bare Hills

How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD County.....City or town..... Bare Hills, Balt Co  
(If outside city or town limits, write RURAL and give nearest town)Street No..... Woods of Bare Hills  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Donald D Winegar

## 3. (b) Social Security Number

none

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Single

## 6.(b) Name of husband or wife .....

6.(c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.) Feb 25 - 1930

## 8. AGE:

16 Years1 Months18 Days

It less than one day

..... hrs. .... min.

9. Birthplace Birmingham Ala.

(Town, county, and estate)

## 10. Usual occupation

School

## 11. Industry or business

School

## FATHER

12. Name..... Louis M. Winegar13. Birthplace Birmingham Ala

## MOTHER

14. Maiden name..... Betty Lee Jones15. Birthplace Birmingham Ala16. Informant..... Louis WinegarAddress 62 Reed St.17. Burial  
(Burial, cremation, or removal, Which?)Date thereof..... April 17-46  
(month) (day) (year)Cemetery or crematory..... Birmingham CemeteryLocation..... Birmingham Ala.18. Funeral director..... Charles P. TowellAddress 2427 Edmondson Ave.19. 4/15 1946 G. W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 13 1946 at 1230 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to ..... 19.....

and that I last saw him..... 19.....

## Immediate cause of death.....

Gunshot thru anterior chest, lungs and heart  
Accident

Due to.....

Due to.....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of..... April 13, 1946Where did injury occur? Bare Hills, Baltimore Co. MD.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) WoodsMeans of injury Companion tripped tripping injured at work? No23. SIGNATURE..... Rollin C. Hudson MD. DHE

M. D. or other

Address..... Towson, Md Date signed 4/13/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

03574

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Baltimore  
 City or town River Van Road, Chase, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore  
 City or town Twin River Beach  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. River Van Road, Chase, Md.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Orie E. Wise

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife Anne M. Wise6.(c) If alive, give age 62 years7. Birth date of deceased (mo., day, yr.) December 15, 18868. AGE: Years 59 Months 4 Days 15 If less than one day  
.....hrs. ....min.9. Birthplace Talbot County, Md.  
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name William Wise13. Birthplace Talbot County, Md.

14. Maiden name

15. Birthplace

16. Informant Mrs. Anne M. WiseAddress River Van Road, Chase, Md.17. Burial Date thereof 5/31/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Holy Redeemer CemeteryLocation 4830 Belair Road18. Funeral director Howard W. Blight Jr.Address 4914 Belair Road19. 5 1 46  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH April 30 19 46 at 2 7 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 2 19 45 to April 30 19 46and that I last saw him alive on April 30 19 46

Immediate cause of death

Left HemiplegiaMyocardial InsufficiencyDue to Hypertensive Cardio-Vascular Disease

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Un Dr. KurowskiAddress 2529 Eastern Ave M. D. or otherDate signed 5/1/46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-1

## CERTIFICATE OF DEATH

03575

Reg. Dist. No. 30

### 1. PLACE OF DEATH:

County Balto. co. 16 Fusting Ave.

City or town Catonsville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balto.

City or town Catonsville Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 16 Fusting Ave.  
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR \_\_\_\_\_

### 3. (a) FULL NAME

Charles W Wisner

### 3. (b) Social Security Number

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced

Widowed

B (b) Name of husband or wife Mary E

6 (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Jan. 5 1846

8. AGE: Years 100 Months 3 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Retiered

11. Industry or business

12. Name Jacob Wisner

13. Birthplace Maryland

14. Maiden name Emily Bowen

15. Birthplace Baltimore Co. Md.

16. Informant Dr. Jacob Wisner

Address 2125 Maryland Ave.

17. Burial Date thereof 4/19/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Druid ridge Cent.

Location Reposited

18. Funeral director John C. Mitchell How

Address 1200 Eutaw Place Bal to. Md

19. 4-18-46 19 \_\_\_\_\_  
(Date rec'd by registrar) Registrar Adk

### MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 17 1946 at 12:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 7 1946 to Apr 17 1946 and that I last saw him alive on Apr. 17 1946.

Immediate cause of death Chr. Myocarditis DURATION unknown

Due to Senile Changes

Due to \_\_\_\_\_

Other conditions Arterio sclerosis unknown

(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE M. Hening M.D. M. D. or other \_\_\_\_\_

Address Catonsville 28 Md Date signed 4/17/46

MARGIN RESERVED FOR BINDING

VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PHYSICIAN  
Please underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

## CERTIFICATE OF DEATH

03576

Reg. Dist. No. 191 31

## 1. PLACE OF DEATH:

County BaltimoreCity or town Rosedale  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Ellicott City  
(If outside city or town limits, write RURAL and give nearest town)Street No. Rogers Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Wesley Raymond Wolfe

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Grace I Wolfe7. Birth date of deceased (mo., day, yr.) Oct. 28, 1900 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 45 Months 5 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Auto Dealer

11. Industry or business

12. Name Alexander Wolfe13. Birthplace Ind.14. Maiden name Bessie Titus15. Birthplace Va.16. Informant Mrs. Grace WolfeAddress Ellicott City Ind17. Burial Date thereof 4-19-1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Good ShepherdLocation Ellicott City Ind.18. Funeral director J. H. Sig. in BaltimoreAddress Ellicott City Ind19. April 18, 1946 John B. Longman  
(Date rec'd by registrar) (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 16 1946 at 4:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 16 1946 to Apr 16 1946 and that I last saw him alive on 4-16-46 1946Immediate cause of death Angina Pectoris DURATION 2 1/2 yrs.

Due to

Due to

Other conditions Diabetes 2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide None Date of \_\_\_\_\_Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE J. D. Caples M.D. M. D. or other Med. Exam.Address Registration Ind Date signed 4-16-46

RECEIVED  
MAY 2 1946  
BUREAU V. M.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

13577

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Balto.  
 City or town Sparrows point  
 (If outside city or town limits, write RURAL NEAR and give town)  
 Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.  
 City or town Sparrows point Ward No. \_\_\_\_\_  
 (If outside city or town limits, write RURAL NEAR and give town)

Street No. \_\_\_\_\_  
 (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

## 3. (a) FULL NAME

Frederick W. Yeager

## 3. (b) Social Security Number

213-09-0573

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary E. Yeager

6. (c) If alive, give age

60 years

7. Birth date of deceased (mo., day, yr.)

January 25, 1883

8. AGE:

Years

Months

Days

If less than one day

63

hrs.

min.

9. Birthplace

Pennsylvania  
(Town, county, and state)

10. Usual occupation

Molder

11. Industry or business

Beth Steel Co.

MOTHER FATHER

12. Name

William Yeager

13. Birthplace

Pennsylvania

14. Maiden name

Mary Kaldwasser

15. Birthplace

Pa.

16. Informant

Mr. Frederick Yeager

Address

720 E. St. Sparrows point

17.

Burial

Date thereof

4/30/46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

East Harrisburg Cem.

Location

Harrisburg, Pa.

18. Funeral director

John F. Henry Inc.

Address

715 - Light St.

19.

4/19/46

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 27

19

46, at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January

19

46, toApril 27

19

46, and that I last saw him alive onApril 26

19

46.

Immediate cause of death

Coronary Occlusion

DURATION

7 days

Due to

Arterio sclerotic Heart  
disease

?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

## PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Dr. J. D. ...

M. D. or other

Address

520 D St. Sp R 19

Date signed

4/26/46

MARGIN RESERVED FOR BINDING

VS A15

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124E)

## CERTIFICATE OF DEATH

Reg. Diat. No. 03578 8 30

## 1. PLACE OF DEATH:

County... BALTIMORE  
 City or town... CATONSVILLE  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 16 days  
 Hospital, institution, or street address where death occurred:  
HARLEM LODGE  
 How long in hospital or institution? 16 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County...  
 City or town... BALTIMORE  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 710 S. BOND STREET  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

DOMINICA ZIELACHOWSKI  
Zelichowska

## 3. (b) Social Security Number

4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOWED

## MEDICAL CERTIFICATION

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age... years

8. AGE: Years 56 Months Days It less than one day  
 hrs. min.

9. Birthplace... POLAND

(Town, county, and state)

10. Usual occupation... TAVERN OWNER11. Industry or business... ENTERTAINMENT

FATHER MOTHER

12. Name Marij Kasmachewski13. Birthplace Poland14. Maiden name Sophia Rogalska15. Birthplace Poland16. Informant Stanislaus ZelichowskiAddress 710 S. Bond Street17. Burial Date thereof 4-17-46

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Holy Rosary Cem.Location Balta. Calvert18. Funeral director John M. WeberAddress 401 J. Chester Street19. 4-16-46 19 46 Registrar

(Date rec'd by registrar)

20. DATE OF DEATH April 13 19 46 at 7:35 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

MARCH 29 19 46 to April 13 19 46and that I last saw h. er alive on April 13 19 46Immediate cause of death... CARDIAC DECOMPENSATION

DURATION

4 hrs.Due to... ABDOMINAL ASCITES3 wks. plusDue to... CIRRHOSIS LIVER2Other conditions... MENTAL DETERIORATION

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ....

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur J. Michalland, MD

M. D. of other

Address Harlem Lodge Date signed 4/13/46Address Catonville, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH

County BaltimoreCity or town Bundalk 22 Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? one yearHospital, institution, or street address where death occurred: 850 Oakleigh Beach Rd

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BellsCity or town Bundalk 22 Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. 850 Oakleigh Beach  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Nancy Lee Zimmerman

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

W. Premature infant

## 6. (a) Single, married, widowed or divorced

## 6. (b) Name of husband or wife

## 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) April 6 - 468. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 3 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Bundalk Md.  
(Town, county, and state)10. Usual occupation infant

## 11. Industry or business

12. Name Richard Eugene Zimmerman13. Birthplace Johnstown Pa14. Maiden name Mary Jane Swain15. Birthplace Hallsboro Pa16. Informant Richard ZimmermanAddress 850 Oakleigh Beach17. Buried Date thereof April 12 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory New CathedralLocation Old Spaulding Rd - Baltimore18. Funeral director Harold WitzkeAddress 4101 Edmondson Ave19. April 11 - 46 Dawson T. Harber  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 - 1946 at 11<sup>30</sup> P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 - 1946 to April 9 - 1946and that I last saw her alive on April 9 - 1946Immediate cause of death Premature infant  
4 1/2 lbs.DURATION  
3 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Dawson T. HarberAddress Sparrow Point 19 Md Date signed 4/14/46

RECEIVED  
APR 13 1946  
BUREAU V.S.